

# **Somewhere there's a silver lining: women's experiences of infertility on the Cape Flats.**

Bianca Davids

DVDBIA002

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***This thesis is dedicated to all infertile women who,  
despite their struggle, still believe that there is a silver  
lining somewhere.***

## COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: \_\_\_\_\_

Signed by candidate

Date: 11 February 2008



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## **ABSTRACT:**

In the communities of the Cape Flats, it is expected that all women will bear children and become mothers. Motherhood serves as a social and cultural indicator of femininity and enables women to access social and economic networks that knit them into community. The social and cultural valorization of motherhood in these communities has informed the powerful stigmatization of infertility (or the involuntary non-conformance to motherhood). The stigma associated with infertility affects women in particular, because the inability to bear children is commonly perceived to be a woman's problem. This study explores the cultural constructions of infertility. It examines in particular, the diverse cultural meanings and the stigma associated with infertility. The examination of these cultural meanings challenges the notion that infertility should only be examined in the biomedical realm.

My research was conducted over a seven month period with six infertile women and with women who have borne children from different areas on the Cape Flats. The infertile women were the primary informants. Other informants included the mothers with whom the focus group was conducted and specialist informants who were healthcare professionals. The participants were recruited through the primary health care clinic in Manenberg, the network of community newspapers, The Daily Voice and through my own social network. Qualitative research methods were used. The study also used participatory research methods involved because the participants played an active role in the construction of the research process and interview schedules. The primary information used was obtained from in-depth interviews and journals kept by the infertile women. For comparative purposes, a focus group was conducted with a group of mothers.

The study illustrates that on the Cape Flats, infertility is constructed as a major cultural and social problem for women. The stigma attached to infertility draws its power from the social and cultural meanings associated with inability of infertile women to live up to the expectation that every adult woman will become a mother. The effects of the social stigma of infertility are especially profound. As I show, bio-medicine does offer some solution, but only to the few who can afford it.

# CONTENTS

<b>Dedication</b>	i
<b>Declaration</b>	ii
<b>Acknowledgements</b>	iii
<b>Abstract</b>	iv
<b>Contents</b>	v
<b>Chapter 1: Daughters of Eve</b>	1
1.1 Introduction	1
1.2 Research Aim	4
1.3 Literature Review	5
1.3.1 Biology is destiny: the importance of motherhood as social identity and the feminist critique	8
1.3.2 Infertility in the West	16
1.3.3 Infertility in Africa and the developing world	21
<b>Chapter 2: Constructing the Methodology</b>	38
2.1 The Research Sample	38
2.2 Area of Study	41
2.3 Relevance of Feminist Methodology	43
2.4 Negotiating Access	48
2.5 Ethical Considerations	58
2.6 Methods Used	60

<b>Chapter 3: Searching for Answers</b>	<b>72</b>
3.1. Infertile women	75
3.1.1 Roxanne	76
3.1.2 Desiree	77
3.1.3 Angel	79
3.1.4 Aquifa	80
3.1.5 Sarah	81
3.1.6 Veon	81
3.2. Social Pressure to attain motherhood	82
3.3 Identifying the problem	83
3.3.1 Education about reproduction: Biology or Social Norms?	85
3.3.2 Sexual education and Social Relations	86
3.3.3 Fertility Risk Test: Factors that contribute to infertility	90
3.4 Finding Answers	94
<b>Chapter 4: Options for Conception</b>	<b>100</b>
4.1 Reproductive technologies	101
4.1.1 In-vitro fertilization	102
4.1.2 Egg donation/sperm donation	105
4.1.3 Surrogate mothers	105
4.2 Alternative treatment	112
4.2.1 Herbal remedies	114
4.2.2 Indigenous healers	117
4.2.3 Religious faith	119

<b>Chapter 5: ‘No Money. No baby’: Infertile women’s access to resources for infertility treatment on the Cape Flats</b>	<b>123</b>
5.1 Roxanne’s Story	124
5.2 Accessing medical treatment	130
5.2.1 The Public health sector	130
5.2.2 The Private health sector	145
5.3 When there is no more hope	150
 <b>Chapter 6: ‘Tjoekoe Ding’: How Cape Flats communities construct infertile women</b>	 <b>154</b>
6.1 Veon’s Story	154
6.2 Stigmatization	162
6.2.1 The pain of gossip	164
6.2.2 Power of words	168
6.3 Lack of Status	169
6.4 Perceived causes of infertility	172
6.5 Partners as Support	179
 <b>Chapter 7: "Djy’s either ‘n ma of niks" – what it means to be a mother in the communities on the Cape Flats</b>	 <b>184</b>
7.1 Aquifa’s Story	185
7.2 Meanings of Motherhood	189
7.2.1 Good mothers	193
7.2.2 Bad mothers	197
7.3 Biological motherhood	201
 <b>Chapter 8: Conclusion</b>	 <b>205</b>
<b>Appendices</b>	<b>214</b>
<b>Bibliography</b>	<b>286</b>

## CHAPTER 1: DAUGHTERS OF EVE

*"It was the eve of the new beginning  
From the ennui of the perfect paradise  
Undeterred by the fear and wrath of God the Father  
Believing that rules should be questioned  
She found in the snake a sounding board for  
Her own reason - an echo of her own  
Desires!  
Shunning ignorance  
Willing to court death for moral awareness  
Her deviant spirit asserted itself and she ate the forbidden fruit  
Choosing freely – she felt exhilarated  
Selflessly – she shared it with her husband  
They saw the light  
And our Mother God celebrating the quest for knowledge  
Rewarded Eve with procreative Gift of nurturing Life itself  
Seeing in her indomitable spirit a creature fit for travail.  
Initiating, questioning, reasoning, searching, choosing, sharing,  
Acting learning, defying –  
This is Eve's legacy to  
Her human sisters  
On the eve of a non-patriarchal world."*

*[Adhis Chetty, 2004:52]*

### 1.1. INTRODUCTION

In many countries in the South<sup>1</sup>, motherhood is regarded as a compulsory mandate for adult women. A woman's role as a mother is used to define her gendered and sexual identity within society. This is empowering for many women, but disempowering for those who either do not want or cannot conceive children. In these communities, a woman's social identity is dependent on her ability to reproduce and nurture offspring (Mikell, 1997). Her personhood is judged by her ability to breastfeed a child as an infant, act as primary caregiver during the early childhood phases and act as the

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<sup>1</sup> In this study, the distinction of North versus South is used. North or Northern countries refer to European countries as well as the United States. Reference to Western ideals refers to ideals or beliefs in Northern countries. The South refers to Africa and other developing countries.

child's primary socialising agent. There are also certain cultural prescriptions and expectations that define motherhood, especially 'good' motherhood.

These social and cultural constructions of motherhood have led to the assumption that all women should naturally be mothers, and indeed want to be mothers. The importance of motherhood is not only enforced by culture but is reinforced by various other spheres in our society (Firestone, 1979; de Beauvoir, 1972).

However, with the dramatic social changes that have occurred globally, there has also been a dramatic change in the importance of motherhood in the lives of women. On the one side of the feminist debate, pro-maternalists still argue that motherhood is compulsory, because womanhood is defined in terms of motherhood, and a woman can only be complete when she has children. On the other side of the debate, some radical feminists such as Simone de Beauvoir (1972) have advocated that women should reject motherhood because it prevents women from achieving their professional aspirations, as they are traditionally seen as the primary caregivers, and childbearing and childrearing will prevent or hamper a woman's entry into the professional sphere. Motherhood as a mandate is an issue that affects all women's lives. Yet we know very little about the social and cultural implications of the failure to mother in working-class or rural communities, especially in African contexts. What happens when women and men are affected by infertility?

There has been minimal research conducted on infertility in Africa and South Africa, and the literature has predominantly taken a biomedical approach. In this study I aim to explore the social and cultural meanings and repercussions of infertility for infertile Coloured women living on the Cape Flats in the Western Cape, South Africa. This is of relevance to South African feminism because women are held responsible for

motherhood and reproduction. I seek to show that infertility is also considered to be solely a woman's problem. For this reason I will focus on infertile women, though there is also a shortage of research on the social and cultural aspects of male infertility in Africa.<sup>2</sup> The failure to conceive therefore seems to hold greater social and personal implications for women. What they are, and how women negotiate them, is the subject of my study. This study also seeks to move current concerns with infertility as solely a biomedical issue to a setting which includes the social and cultural.

This research asks the following questions:

- What are the cultural perceptions of infertile women in Coloured communities on the Cape Flats in the Western Cape and how do they negotiate their infertile status?
- What happens when an infertile woman cannot conform to the dominant ideology of motherhood in her working-class community,?
- How does she negotiate her personhood in her particular context?
- How is she perceived by members of her community?
- How does her infertility impact on her cultural construction of womanhood?
- What are infertile women's perceptions of the importance of motherhood to their feminine identities?
- What medical options and resources are available to infertile women?
- What determines their access to medical resources, and how is this access influenced by their race, class and gender?

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<sup>2</sup> An example of an article on this matter is "You are a man because you have children: experiences, reproductive health knowledge and treatment-seeking behavior among men suffering from couple infertility in South Africa" (2004) by Dyer, S.J., N. Abrahams, Mokoena, N.E and M. Hoffman. Published in Human reproduction 19 (4). Pp960-967



Though this study seeks to explore the social and cultural meanings of infertility, I do not advocate that biomedicine should be ignored totally. In Chapter Three, I will deal with biomedical issues relating to the participants' understanding of infertility.

The subject of my research is important in the context of the Cape Flats, where research on young Coloured women predominantly focuses on the fecundity of the poor.<sup>3</sup> Supporting the view that there is a link between poverty and high birth rates, Preston-Whyte and Allen (1992:212) state the structural contexts for many Coloured people in which early births occur are characterised by "poverty, poor and overcrowded housing, few community recreational facilities, and high unemployment." Constructing the image of Coloured women as highly fecund and not requiring medical assistance to conceive may lead to the invisibility of infertile women. I seek to show that the picture often portrayed in demographic studies is one-sided. My study will investigate how infertile women on the Cape Flats perceive and experience the impact of their infertility on their daily lives.

## **1.2. RESEARCH AIM**

This study seeks to explore the cultural meanings of infertility in communities on the Cape Flats in Cape Town, and how infertile women negotiate their infertile status in these communities.

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<sup>3</sup> An example of the research presented on the high fertility rate in the Coloured community is the article, "Teenage Pregnancy in the Coloured Community", by Eleanor Preston-Whyte and Judith Allen (1992). They state, during the 1970s and 1980s, teenage pregnancies in the Coloured communities especially in the Western Cape aroused concern, comments and subsequent research and intervention. The research paper "Need a child, bear a child" by Nash (1990) advocated increased sex education, contraceptive advice, increased state support for teenage mothers and allowing girls under sixteen to have legal abortions. While some of these suggestions have been implemented in South African society, there remains room for improvement, as the topic of teenage pregnancy remains an issue in these particular contexts. Consequent to Nash's paper, the Human Sciences Research Council (HSRC) launched three further studies on teenage pregnancy in the Cape in the early 1990s.

The aim is broken down into the following tasks:

- To explore the processes women who self-identify as infertile go through as they seek diagnosis of their problem.
- To explore the medical options and resources available to infertile women residing in these communities.
- To explore the meanings that infertile women attach to their experience of being infertile.
- To explore the factors that influence infertile women's access to medical resources.
- To explore whether and how they are stigmatised in their communities
- To explore the impact that the social and cultural meanings of motherhood have on infertile women's lives.

### **1.3. LITERATURE REVIEW**

In this chapter, various arguments on motherhood will be presented. It has been argued that all women are intrinsically maternal, and thus all women should be mothers (Inhorn, 1996). Socially and culturally it is expected that all women will subscribe to the dominant social construction of motherhood. However, reality is not always as precise. Pro-maternalists and radical feminists debate fiercely about the validity and cultural meanings of motherhood. This debate ignores the plight of infertile women. On one hand, they are subjected to intense social and cultural pressure to conform to the norm of bearing children – though they are unable to do

so. On the other, radical feminists argue that women have a choice whether to bear children or not (Allen, 1983) – but infertile women cannot exercise this choice.

While most academic literature about motherhood deals with middle class motherhood in the Northern countries (Phoenix and Woollett, 1991) and to some extent in South Africa (Jeannes, 2002), there is minimal literature available on working-class motherhood, even less on working-class motherhood in the Western Cape, South Africa (Salo, 2004). This reveals a void of investigation into the lives of working-class mothers and how motherhood and the option of choice are perceived in the local context of the Cape Flats. However, while class may affect their representation in academic literature, most women experience pressure in terms of when and how many children to have, and if they want children at all.

While there is debate about the importance of motherhood in modern-day women's lives, it still carries huge social and cultural power in our society. In religious doctrine, especially in the three Abrahamic religions, the concept of motherhood is dominant. As the poem at the beginning of this chapter illustrates, Eve is perceived as the first mother and all women are her daughters because they were born from her body. This reverence for motherhood is not new. It is believed that God granted Eve the ability to bear children (though this gift was also punishment for her transgression in the Garden of Eden). Followers of Christianity, Islam and Judaism all believe that Eve was the first mother, and all three religions emphasize motherhood as important and worthy of reverence.

### *Silence surrounding infertility*

Motherhood gives women access to social reward and status, and there has been much academic focus on motherhood as a practice and as the dominant role for women.

What of the cultural consequences for women who do not conform to the dominant ideology of motherhood? Career women who prioritise their profession above motherhood, women who cannot conceive for various biological reasons, and women who consciously choose not to have children for financial, physical or psychological reasons are commonly constructed as the 'Other' against the 'Us' who are mothers (Oakley, 1980). These other women are labeled abnormal for not having children, selfish for putting their own needs first, less feminine for not conforming to the ultimate feminine ideal of motherhood, as well as being called other derogatory labels which negatively impact their gendered, sexual and adult identities (Inhorn, 1996). Their women counterparts, family, friends and community pity them for missing out on the pleasures of motherhood. However, these negative connotations are not only imposed by outsiders, but often also by these childless women themselves, especially, as I will show, the involuntarily infertile women. They see themselves as inadequate, as failures, and punished by God or a Higher Power.

Most of the issues associated with childlessness focus on the negative implications and rarely mention positive consequences, such as having more time to pursue other opportunities (Pheffer, 1988). While it is argued that women have a choice whether or not they want to be mothers, the pervasiveness of motherhood as an ideal outweighs any other roles for women.

I will now address this issue by presenting the motherhood debate between social theorists who support the importance of motherhood and those who argue against it.

Next I will present representations of infertility in Northern literature, and finally, I will present literature that explores infertility in Africa and the developing world.

### **1.3.1. Biology is destiny: the importance of motherhood as social identity and the feminist critique**

In the 1950s Abraham Stone, Director of the Margaret Sanger Research Foundation<sup>4</sup> in the United States defined how femininity is intrinsically linked with biological motherhood within a particular culture. He stated, "For conception to take place a woman must be a woman. Not only must she have the physical structure and hormones of a woman but she must feel she is a woman and accept it. A girl child becomes and feels herself a developing woman if she has made proper identification with her own mother and has learned to accept her femininity, and also masculinity as represented by her father and later by her husband. Being a woman means acceptance of her role, often defined culturally that conceiving and bearing a child is her primary role. Being a woman means complete readiness to look forward to the delivery of that child, when sufficiently nourished by her, to take its place as an infant in the outside world. Being a woman means her feeling of her own readiness and capability to rear that child and aid in its physical, emotional and mental development." (Cited in May, 1998:198). Stone implicitly linked the biological ability to bear children with a woman's key social identity as mother. Although this statement was made in the 1950s, this type of ideology is still found in contemporary society. Motherhood is not only a potent symbol of womanhood but in many societies also gives a woman her primary identity. While it must be acknowledged that womanhood and self have

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<sup>4</sup> The Sanger foundation was pro-contraception. Abraham Stone's statement supports the argument that motherhood should only be for women who are financially and socially ready to bear children. However, he does acknowledge that femininity is intertwined with biological motherhood.

varying importance in different societies, motherhood remains important across various cultural and socio-economic boundaries.

Supporting the idea that motherhood is culturally linked to a woman's identity, Marcia Inhorn (1996) states that motherhood is a mandate for all Egyptian women. The inability to conform to motherhood places infertile women under the threat of being perceived by others and themselves as lacking something fundamental which defines their identity. In many African cultural contexts such as ours, "motherhood is considered to 'complete' a woman on multiple meaningful levels - as a whole human being with a holistic social identity and self concept, and as an integral woman who has passed beyond the transitional state of the newlywed to assume the normal rights, duties, and responsibilities of married womanhood." (Inhorn 1996:57). The achievement of motherhood implies both individual and social growth and maturation, the importance of which cannot be underestimated. In these pro-natal (and so, pro-maternal) cultural contexts, voluntary or involuntary infertility (an inability to conform to the dominant ideology of motherhood) is not only perceived as socially unacceptable and an obstacle to motherhood but also prevents a woman from achieving social personhood, and leads to the questioning of a woman's gendered and sexual identity, as well as her sense of selfhood.

Most of the articles on theories of motherhood reviewed below focus on the Western notion of middle-class motherhood.

In supporting the evidence of the power that motherhood has in the construction of women's identity, Woollett (1991) states that whether or not women want to become mothers, motherhood is important in relation to all women's lives because women are defined by their relationship with motherhood. The construction that all heterosexual

women aspire to become biological mothers has led to the stigmatisation of women who do not. Those who do not share this aspiration have to justify their failure to identify with, or rejection of, this identity. The pervasiveness of the dominant ideology of motherhood often begins very early in a girl's life. Young girls are socialized into femininity through playful imitation of motherhood roles. The simple game of 'house' could be seen as a foundational experience to the later societal expectations of motherhood (Woollett, 1991).

Further elaboration on motherhood as a primary social identity is provided by Anne Phoenix and Anne Woollett in their article 'Motherhood: Social Construction, Politics and Psychology' (1991). The main objective of their study is to examine how motherhood is a socially-constructed ideology, and how this ideology creates an idealised construction of a good mother in the context of the United Kingdom. They argue that motherhood is romanticised by society and seen as the ultimate physical and emotional achievement for women. However, they state that when (not if) women become mothers, they realise that the real difficulties they experience point to the social devaluation of motherhood. While motherhood is socially valued as women's primary role, it is given little economic value. Work outside the domestic sphere (and particularly male work) is given greater economic importance than motherhood. In this way, gendered inequalities between men and women are perpetuated and patriarchy is upheld.

Woollett (1991) states that according to this dominant ideology, which is still current, the perfect situation in which childbearing and childrearing should occur is one in which both parents are over twenty but younger than forty (considered too old), and married before the birth of the child. After childbirth, a gendered division of labour

should occur, the woman stays at home with the baby, while the man engages in formal employment outside the home.

Furthermore, Phoenix and Woollett (1991) state, studies on the disjuncture between social ideology and the realities of motherhood point to mothers as being perceived socially as the primary caregivers. Mothers are responsible for equipping their children with the necessary social skills to make them well-adapted citizens in their particular society. The notion that children's socialisation should be a mother's sole responsibility has been accompanied by an emphasis on rearing children in the 'right' heterosexual and familial circumstances, however limited they might be. It is advocated that children should be reared in real and not 'pretend' families. Lesbian, gay or single-parent families are considered 'pretend' families as they do not conform to heterosexual family norms.<sup>5</sup> The appropriate age and the circumstances in which women should rear their children are also prescribed by political statements. Teenage mothers, working mothers and single mothers are all types of 'abnormal' motherhood which are censured. These women's children are seen as being more likely to be problematic for society or in need of welfare benefits. Despite the fact that cohabitation and divorce rates have increased in the United Kingdom and that women still choose to parent despite these circumstances, dominant ideologies still require a woman to be married when having children.

Mothering is a central aspect of women's lives and this central role is reflected through its importance in feminist theorising about it. Joyce Trebilcock (1983) addresses mothering practices in patriarchal societies, and the strategies women use to redefine these practices in the United States. She supports the argument that

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<sup>5</sup> See Kath Weston, 1991. Her study, from the United States of America, challenges the argument that only heterosexual women can be mothers. In the local context, see Vanessa Neophytou's article "Lesbian Mothers" (1994), which investigates lesbian motherhood in South Africa.



motherhood reinforces patriarchy, which consequently subordinates women. Trebilcot (1983) states that in many societies, women are under pressure to conform to childbearing and childrearing norms. Women who defy this discourse come under scrutiny. Furthermore, Trebilcot (1983) states that within patriarchal societies, mothering also creates and reinforces various hierarchical social arrangements associated with race and nationalism.<sup>6</sup>

Many women's response to conventional mothering has been a refusal to adhere to dominant prescriptions regarding motherhood. In this way they attempt to redefine the meanings and practices of motherhood (Trebilcot, 1983). Women's reproductive ability is the most significant difference between men and women and is used to maintain and reinforce patriarchal structures in society. In contemporary society, women have recreated the meanings attached to motherhood and started to exercise more power through control over their reproduction or refusing to bear children (Miller, 2005).

Another positive result of this reinvention of motherhood is the freedom that it provides childless women and women with reproductive problems to freely choose whether they want to be mothers or whether they want to pursue a career, and when and how they want to be mothers.

Not all women buy into the motherhood role. Many radical feminist and lesbian feminist authors advocate that women should reject motherhood as the sole aspect of their feminine identities. In Jefner Allen's (1983) article "Motherhood: The annihilation of motherhood", she advocates a rejection of motherhood based on the

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<sup>6</sup> See Wells (1991), McClintock (1997) and Fester (1998) for examples of how South African women used their role as mothers in nationalist struggles.

grounds that mothering is dangerous to women. She bases her argument on Simone De Beauvoir's thesis that women's lack of social power is based upon the biology of reproduction. Her argument is located in the cultural context of the United States of America. She defines a mother as a woman who only exists as the womb and wife of a man; thus, she only reproduces for the sake of men. "A mother is she whose body is used as a resource to reproduce men and the world of men, understood both as the biological children of patriarchy and as ideas and material goods of the patriarchal culture. Motherhood is dangerous to women because it continues the structure within which females must be women and mothers and, conversely, because it denies to females the creation of a subjectivity and world that is open and free." (1983:315).

Allen (1983) also criticises the assumption that all women have an inherent maternal instinct, and that motherhood is natural. She states that from a radical feminist perspective, women feel that they are compelled to be mothers due to the importance of motherhood for women's identities in a patriarchal society. It is considered to be a natural phenomenon. But Allen (1983) argues that motherhood is not natural. Women's biological ability to reproduce is given social meaning, which places them in a socially powerless position in relation to men. Allen (1983), along with other radical feminists such as Shulamith Firestone, argues that in a patriarchal society women must become biological mothers to be recognised as persons. As my research will show, this type of reasoning has enormous social implications, particularly for infertile women. If they are unable to conceive in a pro-natalist society, how does it affect their social status?

More recently, Tina Miller (2005) explores the competing pressure between motherhood and the professional aspirations that young middle-class women in

contemporary society face. Miller (2005) states that in many Northern countries, reproductive patterns and practices have changed over time. Increasingly, if a woman decides to become a mother, it will either happen early in her life as a teenage mother or later in life when her career has been established. The choice to become a mother may occur within a relationship or not. Furthermore, Miller (2005) states that changes in the patterns of childbearing hold implications for women's personal lives. Yet their experiences of motherhood or not parenting are shaped by social and cultural contexts. "Indeed, there is some way that women becoming mothers can experience their transition as confusingly uncertain and risky at a time when biomedical, expert knowledge has apparently provided greater scientific certainty than at any other time before. By focusing on women's experiences of transition to motherhood in contemporary society we can see the ways in which biological is overlaid by societal and cultural in the Western world: and how motherhood is differently patterned and shaped in different contexts." ( Miller, 2005:6). Furthermore, Miller (2005) argues that the dominant ideology of motherhood remains rooted in assumptions of biological determinism and the idea that all women are predestined to become mothers. Fundamental to this ideology is that motherhood is instinctive and universally constant. However, mothering, like any other relationship, is socially constructed.

Similarly, what it means to be a good mother has also changed. Lewis (1991) states that the motherhood mandate is a powerful yet unspoken rule that assumes that all women should be mothers, all women will be good mothers, and motherhood should be women's primary role. This rule does not exclude the possibility of employment, but the 'ideal' mother does not work outside the domestic sphere when her children are still dependent on her, nor does the 'ideal' mother value her work as more important

than her role as a mother. The result of this belief has been that working mothers, especially those employed full-time or those committed to their career, are seen as deviant. This perception has resulted in working mothers being blamed for issues such as inadequate child development and marital breakdown. In practice, however, Lewis indicates that in the UK most women do not conform to this norm due the fact that most women are employed before their children are sixteen years old. Miller's (2005) definition of good mothering shows that society has moved away from the notion of good motherhood as reported by Lewis. Miller (2005:55) states "Good parenting, and specifically good mothering, is premised on ideas of being with children, fulfilling the demands of intensive nurturing, whilst at the same time it involves taking paid work and providing financially for the child."

Lewis (1991) supports the argument that this idea of the good mother is only aimed at white middle-class mothers. She states that in contemporary society, a new cultural directive of motherhood has emerged that is contrary to the dominant ideology. This directive states that women, especially middle-class, educated and intelligent women, should not allow their potential to be wasted in the domestic sphere. Thus, there is a failure to acknowledge the different lived realities of different women from other ethnic or economic backgrounds. Miller (2005) supports this, stating that class, race and culture are factors which affect an individual's expectations of motherhood. Motherhood is a complex experience and goes beyond the biological occurrence of childbirth.

These articles on theories of motherhood all focus on the Northern notion of middle-class motherhood. An obvious assumption is that there is a difference between

Northern and Southern (and specifically South African) notions of motherhood. But Jeannes (2002) states that the minimal literature available on motherhood in South Africa perpetuates the sentiments expressed in Northern-based, white middle-class theories, and neglects the experiences of motherhood in the South, and especially in Africa. Ironically, it has been observed that South African women are subjected to gender-specific role prescription equally or even more so than their Western counterparts. Jeannes (2002) cites an example from Pereira (1997) on the popularity of Winnie Mandela during the Apartheid struggle. Not only was she seen as the symbolic 'Mother of the Nation', nurturing a country engaged in a freedom struggle, but also as being responsible for the nurturing of her own children. Implicit in this example is the reification of all women as mothers. Thus, Jeannes argues that the deterministic notion of motherhood is also found in the limited literature on South African motherhood.

### **1.3.2. Infertility in the West**

Various studies on infertility have been conducted, mainly in Northern (European and United States) contexts. Most of this literature has taken a biomedical approach. Stickler (1992) defines the approach in the following way: "With few exceptions, medical literature on reproduction and infertility is limited to biological aspects of reproduction and medical interventions to relieve or circumvent the causes of infertility. The social and emotional meaning of infertility for individual couples is therefore ignored." [Cited in Denny 1996:218]. However, given the dearth of literature on the social ramifications of infertility in the Southern contexts, these studies are of relevance to the research topic. The articles in this section will deal with

the social stigma attached to infertility, the implications of reproductive technologies for women and how the victim herself is blamed for her infertile status.

Pheffer's (1988) article "Artificial Insemination, In-Vitro Fertilization and the Stigma of Infertility" looks at how societal perceptions of infertility have had severe consequences for infertile women in the United Kingdom. This article highlights the importance of contextualising infertility, historically and culturally. Pheffer argues that the omission of certain contextual factors, especially social factors, compounds the stigmatisation of those deemed infertile. Pheffer addresses the commercialisation of reproductive technologies and the problems thereof. She argues that social and historical contextualisation of infertile patients should take precedence over the financial gain achieved from new reproductive technologies.

Pheffer (1988) states that during the 1980s, reproductive technologies used in treatment of infertility were often seen as a controversial issue. Those opposed saw these advancements as unethical and ill-advised because they were interfering with the creation of life. Emphasis was placed on the ethical aspects of these methods, to the exclusion of any discussion on the historical and social contexts of infertility.

Pheffer (1988) argues that by ignoring these aspects, theorists are unable to persuasively challenge the different and often opposing reasons for the interest in reproductive technologies. Furthermore, Pheffer (1988:82) states the "absence of social and historical context has had an unfortunate consequence for infertile men and women, which is that in the course of considerable public exposure given to infertility, the stigma of infertility has been compounded." Thus, the most important role of providing a social context for infertility is to deconstruct the stigma of infertility.

Pheffer attempts to examine the causes of infertility, but in the available literature, social factors which could point to causes are not taken into consideration. Infertility is accepted as inexplicable. In the UK, the only available infertility statistics are unreliable estimates of people who blame their infertility on the failure of their reproductive organs. These did not include information on class, marital status, sexual orientation, ethnicity or religious affiliation, and leave no provision for any explanation of why infertile people want children. It appears that infertility itself becomes a person's main identifying characteristic. But the omission of crucial personal information is in reality not abnormal, merely the hallmark of a socially stigmatised condition. Thus, Pheffer concludes, infertility is a very depressing and lonely experience for infertile women. This observation is supported in the local context by Dyer et al (2005) who conducted a quantitative study on the psychological distress of 120 women suffering from couple infertility in an urban community in South Africa. Their results showed that "Involuntary childlessness is associated with high levels of psychological distress. Women in abusive relationships are particularly at risk." (Dyer, et al, 2005: 1938). They recommend that the psychological distress that infertile women suffer should be recognised as a negative side-effect of couple infertility, and that effective medical, psychological and socio-cultural strategies should be adopted to address this matter. Their study hints at the importance of socio-cultural context of infertility.

Infertility arouses various emotions, not always negative. Pheffer (1988) argues that the positive aspects of infertility are rarely mentioned in articles and are most often seen by society as selfish behaviour. Pheffer (1988) states that physical infertility and

involuntary childlessness are not synonymous. She cites Porter (1984) who states there is a failure to acknowledge that some people are childless due to social, not physical obstacles. (cited in Pheffer, 1988:83) Fertility is measured through successful conception and the birth of a live child. There is no foolproof means of testing fertility besides trying to conceive. Not all people who are infertile as a consequence of genetics or disease yearn for children or grieve their absence.

My study, like Pheffer's, attempts to address the social meanings and implications of infertility.

One aspect of women's social experiences of infertility is the stigma they suffer. Doyal (1988) looks at how stigma is expressed towards infertile women even in the supposedly unbiased medical profession. She explores this issue by exploring medical professional attitudes towards female patients in the context of the British National Health Service in her article "Infertility - A Life Sentence? Women and the National Health Service". In the United Kingdom, there is an assumption that all women want to be mothers and motherhood should be the key characteristic of womanhood. Thus, women who do not conform to the dominant prescriptions of femininity are stigmatised or blatantly discriminated against.

Doyal (1988:181) states, "Feminism has drawn attention to the stereotypical and often derogatory assumptions about women that underlie much medical practice. Women are generally seen as inferior to men – whatever their social and economic status." It is assumed that women's natural function is reproduction and that becoming a mother



is central to women's identity. However, it is precisely the ability to bear children that makes women different from men and perceived as somehow inferior to men.

However, this attitude is restricted to women who conform to certain societal prescriptions. Women who do not conform to the dominant heterosexual ideology of family and motherhood often face obstacles in their search for access to treatment for infertility. Lesbian and single heterosexual women have been refused treatment because health care professionals hold heterosexual family values. There are moral objections "against those 'undeserving' women" despite the fact that they want to be mothers (Doyal, 1988:182). Doyal's article challenges a narrow biomedical definition of infertility and argues for the inclusion of social and cultural aspects.

Anne Woollett's (1991) article, 'Having Children: Accounts of Childless Women and Women with Reproductive Problems' looks at the impact that infertility has on societal perceptions of motherhood and womanhood in Western societies. Woollett (1991) states that women who delay motherhood or choose not to have children are often expected to explain the reasons for their non-conformity to reproductive norms. Her article documents these reasons. The main reason for subscribing to the dominant ideology of motherhood is the various symbolic and concrete values of motherhood, the most important of which is the inclusion of women into adulthood.

Motherhood symbolises the key to adulthood. Thus, childless or infertile women may not be seen as mature adults. Motherhood is of symbolic importance because it affirms female identity. Through proving their physical and psychological adequacy by producing the next generation, women earn a place within the social system (Woollett, 1991).

Furthermore, Woollett (1991) states that a woman's professional aspirations are linked to her future plans for motherhood. While we live in a society that is publicly committed to sexual equality, the pervasive thought that women with children are the only true women is still powerful. Woollett's argument emphasizes how central motherhood is to women's identity. The literature review has shown that according to societal standards, motherhood is essential to recognising women's achievements in other areas of their lives. The most successful women in our society are mothers who have other activities that supplement motherhood. In this research I will show that childless women are very aware of this ideology and seek to conform to it.

### **1.3.3 Infertility in Africa and the developing world:**

In African contexts, biological mothering translates into enormous social and political status (McClintock, 1997; Salo 2004). As Inhorn (1996) has argued, infertility is not solely a medical problem. Dyer et al (2002) have reported that there has been extensive research on the psychosocial consequences of infertility, but that until recently these studies focused mostly on patients in the developed world.

Dyer et al (2002) address the issue of stigma associated with infertility. They agree there is a gap in research on the social, cultural and psychological consequences of infertility. The few reports they cite that do exist on infertility in Africa indicate high levels of stigmatisation, ostracism, abuse and divorce, and that there is a need for more studies on this matter.

### ***Fertility, Infertility and Population Studies***

For the most part, population studies have also neglected to examine the social and cultural implications of infertility in Africa. This conscious omission of information

feeds the stereotypical construct, in the demographic literature, of Africans as being hyper-fertile. Many population control programmes have been implemented in Africa to control women's fertility (Greenhalgh 1995). These programmes often fail to account for the social and cultural importance of motherhood to the women that they target. Greenhalgh (1995) argues that the cultural understandings of reproduction have been transformed during the last century. Since World War One, increasing fertility rates have "had far reaching consequences for social life. In every region of the world couples have been having fewer children, shrinking the basic unit of social life. Issues surrounding reproduction, once considered the most private and taboo of subjects, have become matters of intense public concern, as neo-Malthusians and environmentalists claim third-world overpopulation as a threat to the future of mankind." (Greenhalgh 1995:3). Marcia C. Inhorn (1996) also argues that population growth has had an impact on the marginalisation of infertile women. Egyptian population scholars and policymakers have negated the significance of infertility as an important social problem by accepting the notion of Egyptian hyper-fertility and their need to control it. Inhorn (1996) states that fertility and infertility are oppositional categories, yet gaining an understanding of one leads to a better understanding of the other. In particular, infertility provides a lens through which beliefs and behaviours on fertility can be viewed, revealing associated beliefs about the importance of motherhood, fatherhood and children in societies.

For population planners and demographers women are perceived only as targets for population control. This focus on one issue of reproductive health, namely family planning, has led to the invisibility of infertility in Africa. This gap in the research was one of the motivating reasons for conducting this study. The number of infertile women in Africa is disturbingly high, yet these women still remain invisible and

preventing pregnancies still takes prominence. Boerma and Mgalla (2005:15) state that it is estimated that three to four million women in sub-Saharan Africa are affected by primary infertility. "As voluntary childlessness is rare in most of sub-Saharan Africa, this is also likely to reflect the number of women (and couples) who see this as a health and social problem, a large number of women can be considered to have secondary infertility, probably more than 13 million women". However, this estimate of infertility will decrease when the number of women who have reached a desired level of fertility is factored in. Boerma and Mgalla (2005) estimate between eight and ten million women in sub-Saharan Africa are currently suffering from infertility.

Turshen (1991) states that African governments and their international advisors show a limited interest in women's health. Maternal and child care health services focus on women as childbearers. They do not include infertility in their definition of reproductive health. Boerma and Mgalla (2005) agree that while infertility is a common occurrence in sub-Saharan Africa, it is an element of reproductive health which has been ignored by researchers and health programmes. The foremost reason for this is the lack of effective, affordable interventions that would assist infertile men and women. I argue that the term *women's health* will only be truly applicable when it includes women's infertility, and until then this issue will remain marginal.

In addition I also want to emphasise the social and cultural meanings of infertility, beyond the conventional biomedical definition. Great importance is placed on the control of reproduction in African societies, by both men and women. Bledsoe and Cohen (1993:69) state that "virtually everyone in Africa, from rural farmer to sophisticated urbanite, experiences intense pressure to become a parent."

Policymakers fail to acknowledge the value that is placed on having children in

African societies. For example, Bledsoe and Cohen (1993) report that in 2000 sub-Saharan Africa's fertility rates remained the highest in the world, despite an increase in contraceptive use and a decrease in fertility rates in Botswana, Kenya and Zimbabwe. Family planning programs continue to encounter strong reactions, ranging from polite acceptance to resentment, because of the intense social pressure to bear children (Bledsoe and Cohen 1993).

They argue that while fertility is highly valued on the African continent, there are two powerful cultural expectations attached to it. The first is that ideally childbearing needs to occur within socially/culturally 'sanctioned' states. From an outsider's perspective, this would mean marriage, but in this context it is to do with undergoing rituals or learning experiences which prepare the individual to be a responsible adult and parent. The second condition is that the child should have an acknowledged social father. However, Bledsoe and Cohen (1993) state that children are not only valued by married women but by unmarried women as well. For example, in Sierra Leone, Christianity and rising levels of education have not changed the perception that unmarried mothers are more acceptable than childless women. While most parents prefer their daughters to be married when they conceive, some desperate parents may pressure an older, educated but unmarried daughter to fall pregnant.

Taking all of this into consideration, it must be remembered that reproduction is a highly gendered process and most issues surrounding this topic relate to women. Failing to recognise the cultural and social value that children have in women's lives, and only focusing on the control of fertility, could have devastating effects on women who do not or cannot conform to the prescriptions that are held up as the ideal, and who are consequently seen as deviant in relation to other women.

Creating an awareness of infertility in Africa could change this perception. However, infertility should not be isolated from women's reproductive health. Programmes should be created that focus on a woman's reproductive health throughout her life and not only when problems occur. White, Zaba et al (2005) state that before the late 1960s, primary infertility was very common on the African continent. In the 'infertility belt' located in central Africa, one in five women did not conceive or give birth by the end of their reproductive years. In various other parts of Africa more than one in ten women were childless. This is much higher than the 3% primary infertility risk due to genetic, anatomic or endocrine factors accepted as a standard level.

White, Zaba et al. (2005) state that in the 1990s national surveys showed that there has been a decrease in women diagnosed with primary infertility, due to the introduction of antibiotics through national health campaigns in the 1950s and 1960s. In most African countries, primary infertility amongst women in their forties has decreased to less than 5%. This rate is on par with infertility rates in countries where primary infertility is not a result of sexually transmitted diseases (STDs) or sexually transmitted infections (STIs). The new issue of concern in maintaining a low infertility rate is the "early onset of sexual intercourse (particularly unprotected intercourse), the high prevalence of STDs and the lack of sexual health services for youth, all of which may lead to an increased incidence of primary infertility in the future" (White, Zaba et al 2005:118). Gerrits (1997) supports this, stating that the increase in attention on infertility in Africa can also be ascribed to the HIV/Aids pandemic, which raised concerns about the spread of STDs.

The few reports about the socio-cultural consequences of infertility in South Africa that do exist have been published by the Infertility Clinic at Groote Schuur Hospital in

Cape Town, in conjunction with the Medical Research Council.<sup>7</sup> Dr. Dyer (senior Director at the Infertility Clinic) has said that though she has done extensive research on infertility, there is little information available about the socio-cultural consequences of infertility on South African women's lives, and more specifically women on the Cape Flats.

Creating knowledge and awareness of infertility and related issues will assist health professionals at facilities such as the Infertility Clinic to understand their patients better. This could lead to the development of a holistic approach to infertile women in the province, instead of the biomedical approach used currently. Supporting the call for the contextualisation of fertility, Greenhalgh (1995:12) states: "In fertility research, the aim would be the creation of 'whole demographics' that contextualise reproductive behavior not only in social and economic terms of conventional theory, but in political and cultural terms as well."

In the African context, researchers have attempted to address social and cultural issues related to infertility. For example, the following anthropological study deals with the socio-cultural aspects of infertility as experienced by infertile women in a matriarchal ethnic group, Macua in Mozambique.. The study entitled "Social and cultural aspects of infertility in Mozambique" was conducted by Trudie Gerrits in 1993 in Montepuez

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<sup>7</sup> "Infertility in South Africa: women's reproductive health knowledge and treatment-seeking behaviour for involuntary childlessness" (2000) by Dyer, S.J., Abrahams N, and M. Hoffman published in **Human Reproduction**, Volume 17(6): p. 1657-1662 is an example of a study conducted by researchers from the Faculty of Health Sciences at the University of Cape Town and the Medical Research council.

(located in the most northern province). Gerrits (1997:40) reports that the way the "Macua women deal with infertility is very much related to social and cultural contextual factors." It is these factors that cause Macua women to be active participants in their quest for a child instead of passive sufferers. The first factor is the matrilineal kinship system. Children are greatly valued by Macua women's families, so infertile women have their families' support in their quest for conception. The second factor is the existence of a plural medical system. Macua women initially seek medical assistance for their infertility. However, there is little faith placed in biomedicine, and these women often choose to consult with traditional healers in their search for answers. The explanations for their infertility are based on their consultations with traditional healers rather than biomedicine. The third factor is the local Macua explanatory models. Having children is not only important to women and their families but to the Macua as a whole, because children guarantee the continuation of the matrilineage. For this reason the possibility of infertility is controlled through pregnancy and initiation ceremonies which educate women and men on how to produce healthy offspring (Gerrits, 1997).

Macua women are able to make their own decisions about their infertile status. They have the support of their families and there is no fear of retaliation from their husbands. Infertile women do not fear abuse or divorce due to their inability to bear children. Instead it is women (or their families) who take the initiative to divorce because in Macua culture it is often speculated that the man is the infertile partner. It is also women who have multiple sexual partners and commit adultery in the hope of conceiving. While it may appear that Macua women's experiences of infertility are opposite to those of infertile women in patriarchal societies, there are some similarities in their experiences. Infertile Macua women also experience social



exclusion. They are excluded from certain ceremonies and social events. It is difficult for infertile women to exist in a society which places tremendous emphasis on children (Gerrits, 1997).

Gerrits' study illustrates that the social and cultural aspects of infertility do have bearing on women's experiences of infertility. It also illustrates that even in a matriarchal society, infertile women experience social exclusion and restrictions due to their childless status. It can be concluded that even in a society in which women have greater autonomy, the motherhood mandate negates this to some extent. It should not be forgotten that women's experiences of infertility in a patriarchal society such as South Africa will be different to those of Macua women.

In patriarchal Western societies, scientific discourse has constructed women's bodies as deficient. Braidotti (1997) states that for thousands of years, the control of women's bodies for reproduction has been the basis of their oppression. She claims that the association of women and deficiency dates back as far as Aristotle. In his *The Generation of Animals*, he based the norm for human bodily organisation on a male model. Under perfect conditions during reproduction, a boy is produced. A female child indicates an error in this process. Aristotle based his argument of the superiority of the male on his theory that sperm carries the essence of life. The female genital apparatus was seen as the passive vessel. "The sperm-centred nature of this early theory of procreation is thus connected to a massive masculine bias in the general Aristotelian theory of subjectivity. For Aristotle, not surprisingly, women are not endowed with a rational soul. The *topos* of women as a sign of abnormality, and therefore of difference as a mark of inferiority, remained unfaltering in Western scientific discourse." (Braidotti 1997:63).

I believe that it is this construction of the female body as inferior in Western scientific discourse which has hampered the investigation of the social and cultural meanings of infertility in Africa and elsewhere. Where there have been attempts to investigate this matter in patriarchal societies, these issues are secondary to the investigation of the biomedical issues of experiences of infertility. For example, in her study on infertility in Gambia, Sundby (1997) sought to gain an understanding of the importance of children to women through looking at women's access to the modern and traditional health care sectors. In this study, the emphasis is not on the biomedical but on the social and cultural meanings of infertility in a context where motherhood is the ultimate identity for which all women should strive. These issues received wider attention when examined in the Western context, and continue to be, showing their pertinence to contemporary society. Although written in a different context, the following article is an example of the insights that can be gained by unpacking the social meanings of infertility in Africa. Though somewhat dated, Inhorn's study, "Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt", an anthropological study of poor, urban, infertile Egyptian women, was the first study of infertility from the African continent to depart from a biomedical approach. Inhorn conducted her ethnographic fieldwork at the University of Alexandria Shatby Hospital between October 1988 and December 1989. The location greatly facilitated her work due to the hospital's patient demographic of poor, urban women. Because of the services provided by the hospital (primary and tertiary care ranging from the provision of contraceptives to an out-patient infertility clinic), Inhorn was able to conduct semi-structured interviews with one hundred infertile women and ninety fertile women<sup>8</sup>, supplemented by participant observation. She was invited to the

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<sup>8</sup> Inhorn (1996) argues that the inclusion of fertile women was important for comparative purposes.

homes of some of the women, where she conducted the less formal aspects of her fieldwork, including talking to husbands, healers, neighbours and family. Though she observed and participated in family and community life, the main focus of her study was the experiences of infertile women themselves.

This book is one of the most fundamental references for this study. Besides important discussion of how infertility affects women's lives on various levels, it also provides the theoretical framework on which this anthropological study is based. Though Inhorn (1996) conducted her research among poor, urban infertile Egyptian women, it is applicable to the Cape Flats. Another factor which makes Inhorn's study attractive is her conscious choice to concentrate on infertile women's experiences. Considering her feminist interest in women's health issues, it was one of her objectives to produce a gynocentric study. She was aware that in Egypt, as in the rest of the world, infertility is considered a woman's problem rather than a man's or a couple's problem.

Inhorn (1996) states that motherhood is the most important social and cultural role for women in Egyptian society. Through it they access social and cultural agency. This is especially so for poor, urban women. Those unable to have children through infertility suffer emotional anguish on a daily basis and are socially stigmatised. They are blamed for their inability to conceive, for the social stigmatisation of this blame and by the internalisation of this blame. Furthermore, they may be stigmatised for being women in a patriarchal society, for being poor in a class-divided society. and for being infertile in a society that valorises motherhood. Thus, it can be argued that these women's identities have all the signs of stigma as defined by Erving Goffman (1963), who states that the term stigma was coined by the ancient Greeks in their quest to expose the undesirable moral status of a person through certain bodily signs. These

were used to distinguish slaves, criminals and other tainted people. In modern society it refers to disgrace rather than the bodily signifier thereof. Goffman (1963:12) defines stigma "as an attribute that makes him (*her*)<sup>9</sup> different from others in the category of persons available for him(*her*) to be, and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He(*she*) is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting affect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap." Dovidio, Major and Crocker (2003:3) add that "Stigma is a powerful phenomenon, inextricably linked to the value placed on varying social identities. It is a social construction that involves at least two fundamental components: (1) the recognition of difference based on some distinguishing characteristic, or 'mark'; and (2) a consequent devaluation of the person."

These attributes of stigma can be applied to various other conditions, most profoundly HIV/Aids. In a study entitled "Stigma, discrimination and violence amongst female sex workers and men who have sex with them in Andhra Pradesh, India", Samuels, Ravi and George (2006) explain why. Stigma and discrimination are based on shame and fear. "One of the major sources of stigma comes from the moral judgment about the sexual behavior that is responsible for the infection. Female sex workers and men who have sex with men also face forms of stigma because they are commonly labeled as carriers of the virus, Stigma builds upon and reinforces existing inequalities within societies resulting in social exclusion, further marginalizing vulnerable groups." (Samuels et al 2006:96).

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<sup>9</sup> My parenthesis

Inhorn (1996) states that women's inability to bear children for their husbands, families, community, religion and nation is a weighty issue for those living in a society where the fertility mandate for all women is pervasive. The social and psychological consequences of their infertility are the most profound. Supporting this view, Dovido, Major and Crocker (2003:5) argue that because stigma is socially defined, the impact and effect of stigma differs across different cultures and periods. Thus, the major negative impact of stigma is the social and psychological implications. Furthermore, Inhorn (1996) states that infertile Egyptian women are unable to access the social and cultural status that is reserved for mothers. Their inability to bear children leads to them being viewed as lesser human beings. The absence of motherhood goes beyond the simple biological and reproductive and has profoundly affects every social relationship that an infertile woman might have.

Inhorn (1996) points out that this need to conform to the dominant ideology of motherhood is based on the pervasive Egyptian assumption that all women have an inherent maternal instinct and that motherhood is natural within Egyptian society. The social qualities needed for childbearing and childrearing are considered part of a woman's nature. Consequently, when women marry they hope to conceive immediately. Despite the monetary cost of childbearing, even the poorest women view motherhood as their primary 'mission' in life. For women in this society, having children provides them with prized social and cultural status and respect. Supporting this view, Goffman (1963) states the stigmatised individual is aware of the social and cultural beliefs within their society. It has been shown that a stigmatised person holds the same beliefs about what constitutes an acceptable social identity as a person who is not stigmatised.

According to Inhorn (1996), infertile women internalise the negativity that is associated with their infertile status. They construct themselves as pitiable, and are pitied by others in their community. They suffer emotional anguish as patients seeking solutions to their infertility. Others see them as being unable to achieve emotional fulfilment. Elaboration on the effect of stigma on the self is provided by Jones, Farina, Hastorf, et al (1984:111). They state "The development of the self-concept is a distinctively social process. Other people are essential to our efforts to acquire knowledge about the self and the evaluation and interpretation of our life experiences. A discrediting mark or stigma necessarily modifies this social process and the interpersonal relationships that are so vital for self-knowledge and self-validation." For a stigmatised individual, creating and maintaining a constant and positive self-concept is a difficult and doubtful process. A key difference between the stigmatised and the unmarked person in the construction of their self-identity is the affective reactions received from other members of society. The reactions, observations, and evaluations expressed by other people are experienced as disproportionately negative by the stigmatised individual. When this occurs, dealing with other people becomes a hardship, something to be anxious about and prevented as much as possible.

Relating this to infertile women, Inhorn (1996) states that the blame women suffer for their infertility, and the internalisation of this blame, is profound. In comparison to other women who have borne children, these poor, infertile Egyptian women feel incomplete and inadequate.

These women are perceived to be lacking two major experiences that define them as person, being namely bearing children and motherhood. Among the urban Egyptian poor, infertile women are labeled 'mother of the missing one' (or 'precious one', or

'compensation'). These names reflect how precious these women's unborn children are, and how the birth of those 'missing' children would be compensation for all the suffering they endure in a society that values a woman's fertility and her offspring so highly. The metaphors and descriptive terms used to label infertile women are instructive. Jones, Farina, Hastorf, et al (1984:5) state, "It is the dramatic essence of the stigmatizing process that a label marking the deviant status is applied, and this marking process typically has devastating consequences for emotions, thought, and behavior. Many words have been applied to the resulting status of the deviant person. He or she is flawed, blemished, discredited, spoiled, or stigmatized. In the classic case the mark or sign of deviance initiates a drastic inference process that engulfs impressions of the deviant target persons and sets up barriers to interaction and intimacy."

The second aspect that is missing is motherhood itself, "with all that it entails for a woman's daily existence and her gendered identities - that is missing and that cannot be found until a woman experiences the birth of a living child. For poor Egyptian women, motherhood is more than a role to be fulfilled along with many other roles, some more or less important. Motherhood is a primary identity, the very source of one's being as a woman." (Inhorn, 1996:65). When a woman is unable to conform to this norm, she is seen as incomplete, less feminine and abnormal. Thus, to be a 'normal' woman, you must be a 'normal' mother, with the emphasis on children being offspring from your own body. Crocker and Quinn (2003:153) state that through being stigmatised, doubts are raised about one's social identity. A person's claim to humanity is questioned due to the inability to conform to the norm set out by society. "One is devalued, spoiled, or flawed in the eyes of others." Goffman (1963:15) continues this theme: based on the assumption of the questionable claim on humanity

by the stigmatised person, we employ different forms of discrimination. However, by doing so, we are unconsciously yet effectively reduce the stigmatised person's quality of life. "We construct a stigma theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as those of social class." We use derogatory terms to distinguish the stigmatised without giving thought to the original meaning of the word.

## **Conclusion**

The prescribed role of motherhood for all women is all-pervasive in Africa, and particularly South Africa. The debate on the importance of motherhood in modern day women's lives is by no means new. The literature on motherhood used in this chapter deals predominantly with middle-class motherhood in the West (Phoenix and Woollett, 1991) and to some extent in South Africa (Jeannes, 2002). Northern-based literature, which centres on middle-class ideals, is applicable to the local context insofar as it assists us in formulating local ideologies of motherhood and meanings ascribed to childlessness. On the one side of the debate, pro-maternalists still argue that motherhood is compulsory, because womanhood is defined in terms of motherhood and a woman can only be complete when she has children. It has been argued that all women are intrinsically maternal and thus all women should be mothers (Inhorn, 1996). Socially and culturally it is expected that all women will subscribe to the dominant social construction of motherhood. A woman's role as mother defines her gendered and sexual identity in society. Many theorists cited in this chapter (Woollett, 1991; Phoenix and Woollett 1991) have argued that a woman's personhood is dependent on her role as a mother. Motherhood is not only a potent



symbol of womanhood but in many societies also gives a woman her primary identity.

On the other side of the debate, some radical feminists, for example Jefner Allen (1983) have advocated that women should reject motherhood because it prevents them from achieving their professional aspirations. The reason is that women are traditionally seen as primary caregivers, and that childbearing and childrearing prevent or hamper women's active competitiveness with men in the professional sphere. Many radical feminist and lesbian feminist authors advocate that women should reject motherhood as the sole aspect of their feminine identities. In this chapter it was argued that motherhood is not natural, rather that it has social meanings which place women in a powerless relationship to men (Allen, 1983). The meanings of motherhood are not rigid and have changed with global social changes. In constitutionally advanced societies such as South Africa and others, women have access to opportunities which would have been unheard of twenty years ago. However, while women's class positions may affect their representation in academic literature, the dominance of the motherhood ideology still has power over women's lives.

Traditionally, infertile women are constructed in opposition to motherhood and the literature on the motherhood debate fails to address whether or not there are differences in the meanings of motherhood held by fertile and infertile women.

There has been little research conducted on infertility in Africa and South Africa. The few reports that exist indicate a high level of stigmatisation, ostracism, abuse and divorce (Dyer et al, 2002). In this chapter I cited studies that have sought to define the social meanings of infertility in Africa. However, literature on infertility in Africa

has predominantly taken a biomedical approach. In addition, population control programmes which have constructed African women as needing assistance in controlling their fertility rather than combating infertility. This one-dimensional focus has led to the invisibility of infertile women. As I have shown, these programmes are not adequate in the African and developing world because they fail to recognise the social and cultural meanings of motherhood.

While theorists working on infertility in the West and in Africa are mindful of their contextual differences, they all argue for more research on the social and cultural implications of infertility on infertile women. I believe that unpacking these implications will lead to a better understanding of the gendered nature of infertility on the Cape Flats. Infertility is socially and culturally constructed as a women's problem and for this reason, this study opted to focus on women's experiences of infertility, though I seek to show that it is an issue that has broader social consequences. By focusing on the meanings of infertility, this study aims to examine the power of motherhood in the communities of the Cape Flats, and consequently the repercussions that failure to conform to this ideology have for infertile women.

Motherhood provides women with social and cultural agency; infertile women are not able to access these rewards, and so are placed in an outsider position within their own communities. This study aims to show the impact that this exclusion has on infertile women's experiences. In the following chapter, I will address the methodological aspects of this study. It will be shown how the stigma and the veil of silence that surrounds infertility on the Cape Flats affects infertile women's lives and influenced various methodological aspects of this study.

## **CHAPTER 2: CONSTRUCTING THE METHODOLOGY**

In this chapter, I will deal with the methodological issues that arose in this study. First I will present a description of the research process, and how the sample of informants was recruited, followed by a description of the area of study. I continue with a discussion of the relevance of feminist methodology to this study, including my reflexivity as a researcher. This is followed by a section dealing with negotiating access, including a presentation of the successes and failures of negotiating access to certain sites. I will deal with the ethical issues that arose during the recruitment process and the research process. Finally, I will present the methods used to gather the data.

This study was conducted on the Cape Flats, on the periphery of the city of Cape Town, where the majority of coloured reside. The participants were recruited from Surrey Estate, Tafelsig, Manenberg, Grassy Park and Hazendal, which are all coloured areas. The research was conducted with six women who have self-identified themselves as infertile. Due to the sensitive nature of this topic, qualitative anthropological and feminist methods were used to collect data, enabling women to relate their stories and experiences of dealing with infertility on the Cape Flats.

### **2.1 RESEARCH SAMPLE**

Because of the silence surrounding infertility among couples on the Cape Flats it was difficult to recruit participants for this study, which led to the use of creative recruitment methods including snowball sampling. I did not have direct access to a readily identifiable research sample. The final sample consisted of five married women and one unmarried woman, all of whom self-identified as infertile, including

one woman who was later diagnosed bio-medically by a medical doctor as being infertile. This self-identification may not correspond with the bio-medical definition of infertility. Nevertheless the women's self-definition as infertile reveals the social and cultural understanding of infertility in the subjects' communities and is used for the purposes of this study. I planned on also interviewing husbands, friends, family members and physicians, in order to see how these parties perceive infertility. In the end this did not occur, for several reasons. Firstly, none of the women's partners were willing to participate, as they were uncomfortable with speaking about and expressing their feelings on, their individual partners' inability to bear children. Secondly, I was not able to access family members' opinions, as some of the subjects did not want to involve relatives in such a delicate issue. I was however able to access the thoughts of physicians who treat infertility, including Dr. Silke Dyer (a director at the Infertility Clinic), the Director of Manenberg Clinic, and my personal gynaecologist, Dr. Bruce Howard.

I have intentionally focused on women's experiences of infertility. This is not so much due to the difficulties faced in the recruitment process, but to infertility being socially and culturally constructed as a woman's problem. Yet, ironically these women's voices are seldom heard. This conscious choice to create a women-centred infertility study is also found in Inhorn's (1996) anthropological study. She states that considering her feminist interest in women's health issues, it was one of her objectives to produce a gynocentric study. When she designed her research she was aware that in Egypt, as in the rest of the world (including the West), infertility is considered a woman's problem. She also argues that it is important to focus on women because it is women's bodies that are subjected to treatment. In support, Oakley (1993) states that

fertility treatment is for the most part gender-specific. Irrespective of which partner has the problem, it is always the women's body that is first subjected to treatment.

My subjects' unwillingness to speak to other parties about their perceptions of infertility hints at the women's own silence surrounding the topic. Infertility is an invisible issue. Women who are infertile are fearful to voice their opinions about their experiences for fear of public judgment and social repercussions for deviating from societal norms. The stigma associated with infertility is very powerful.

The stigma surrounding women's infertility made it difficult to recruit participants. I resorted to creative recruitment methods to identify initial participants and then relied on snowball sampling hereafter. Three of the participants were recruited via a letter published in the community newspapers distributed on the Cape Flats. I recruited one participant through my personal social network, another through a poster placed at Manenberg Clinic, and another through a local tabloid, *The Voice*. The reasons for choosing these methods will be explained later in this chapter.

The sample consisted of six coloured women from different areas on the Cape Flats. Five are married, while one is in a new relationship. One of the participants had a son but has been unable to conceive another child. Their ages range from 22 years to 40 years old. The number of participants is far smaller than the number of women who responded during the recruitment process, but most often the women who responded were desperately seeking instant solutions to their infertility. All the women who participated in this study self-identified as infertile. No one mentioned first being medically diagnosed as being infertile. Thus, while the sample is small, it represents the infertile women who were willing to progress through the whole research process and unpack the social and cultural meanings of their infertility. Also, as will be shown

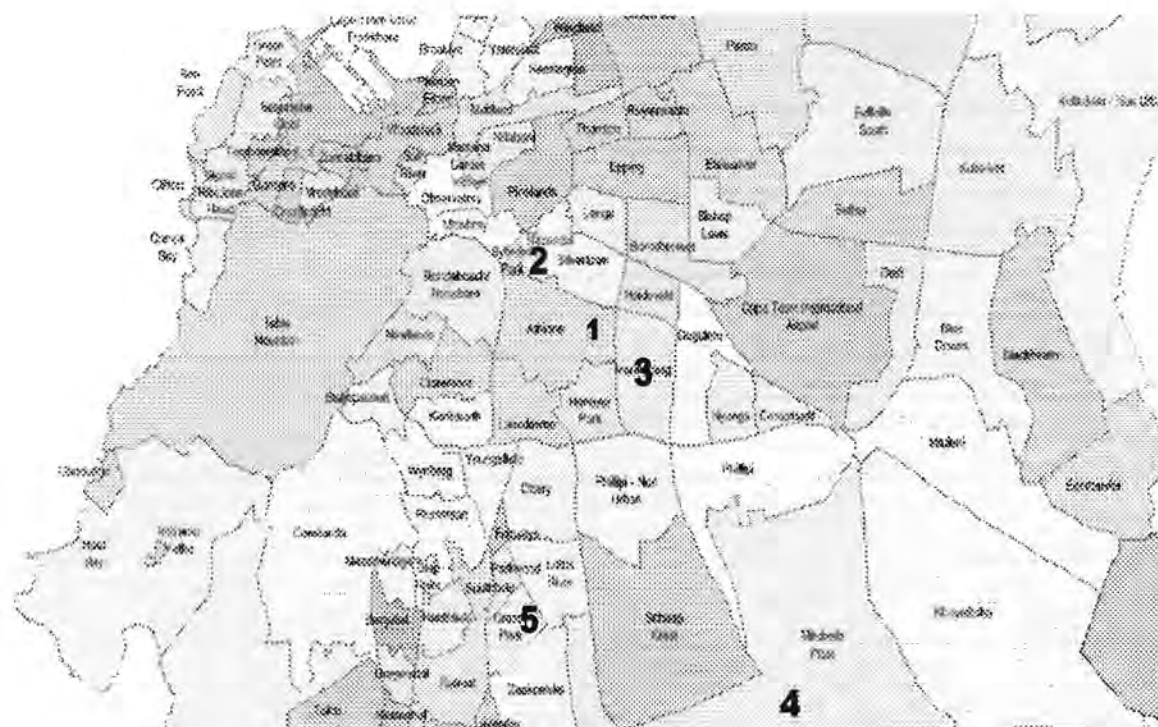
in this chapter, some of the women who self-identified as infertile gained some medical insight into their condition as a result of the research process. Apart from conducting interviews with the infertile women who made up the sample, a focus group was conducted with a group of women from Tafelsig. This was done to supplement and strengthen the statements made by the participants about their experiences of dealing with their infertility in the context of the Cape Flats.

Because of the sensitive nature of the research topic, it was important that the participants were able to express themselves comfortably. I share a racial identity with these women. I speak English and Afrikaans like they do and I felt that this would assist me in conducting the study. Coloured people on the Cape Flats speak English and Afrikaans, but most often they tend to switch between these two languages often in the same sentence. My fluency in both languages facilitated the research, because it allowed for easy flow of conversation. This sample is not representative. While I anticipated a small sample, the severity of the silence surrounding infertility was manifested through the difficulty experienced in recruiting participants. I will deal with this issue in detail later on in this chapter, and as I explore these women's identities further in Chapter Three.

## **2.2. AREA OF STUDY**

The women recruited for this study live in different areas on the Cape Flats (see Figure 1), specifically Surrey Estate, part of Athlone (no. 1 on the map), Hazendal (no. 2), Manenberg (no. 3), Tafelsig, part of Mitchell's Plain (no. 4) and Grassy Park (no. 5).

**Figure 1. Map of research setting**



- Key:
1. Surrey Estate (in Athlone)
  2. Hazendal
  3. Manenberg
  4. Tafelsig (in Mitchell's Plain)
  5. Grassy Park

The following socio-economic information, drawn from Statistics South Africa's Census 2001, shows the differences and similarities between the areas these women inhabit. This provides insight into the struggles they face when attempting to access medical resources in dealing with infertility.

All these areas have a predominantly Coloured population – Athlone 70%<sup>8</sup>, Hazendal 96%, Manenberg 94%, Tafelsig 90%<sup>9</sup> and Grassy Park 94%. While the Indian/Asian group is a small minority in other areas, they represent 24% of the population in

<sup>8</sup> Data for Athlone was used as there is no statistical information specifically for Surrey Estate.

<sup>9</sup> This is the population statistic for the greater Mitchell's Plain area. There is no separate Census data for Tafelsig.

Athlone. The dominant language in Athlone and Grassy Park is English, which is spoken by more than 70% of the residents. In comparison, the dominant language in Hazendal, Manenberg and Tafelsig is Afrikaans. In both Athlone and Grassy Park, 88% of economically active people are employed. During the same period a lower employment rate, ranged from 71% in Hazendal, 66% in Manenberg and 74% in Tafelsig. In 2001, the unemployment rate was 12% in both Athlone and Grassy Park, rising to 29% in Hazendal, 34% in Manenberg and 33% in Tafelsig. A finer socio-economic difference this distinguishes Athlone, Grassy Park and Hazendal as better off than Manenberg and Tafelsig.

According to Census 2001, 60% in Grassy Park, 55% in Athlone and Mitchell's Plain, 40% in Hazendal and 37% in Manenberg earned R1601 to R6400 per month. The lower income bracket of between zero and R1600 per month was earned by 59% in Manenberg, 53% in Hazendal, 41% in Mitchell's Plain, 28% in Grassy Park and 26% in Athlone (Census 2001).

## **2.3 RELEVANCE OF FEMINIST METHODOLOGY**

Feminist researchers try to address the gender inequalities that are perpetuated through traditional research methodologies and that silences women's voices and experiences. However, even in feminist research, there is a difference between the power held by the researcher and the researched. The researcher's insider-outsider identity provides a common ground from which to start. However the researcher sees informants as subjects and this illustrates the power differential which locates the researcher as being more knowledgeable than the informant. Feminist methodology



seeks to overturn this power relationship. This study is embedded in a feminist methodology in that it addresses issues related to women's reproduction within the context of unequal gender power relations. In my research project there is the processual evolution of a 'friendship' between myself the researcher and participants, so that knowledge and power relations were blurred by the end of the study (Oakley 1981, Morsy 1988).

I also followed a feminist methodology because my interest in this topic began with my own experiences with infertility problems and the attendant social perceptions of these problems. It was based on my own awareness that I may be infertile and that I experience the silence and social stigma associated with this condition. I was curious to investigate how other women experience infertility in South African society.

Oakley (1981) states that "the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical" and the interviewer invests herself into the research relationship. This is what I have done. The research lens also focused on me, as a woman dealing with infertility, and widens to include my own community, by investigating the impact of infertility on the lives of women on the Cape Flats.

There are advantages and disadvantages to being an insider-outsider ethnographer. Kondo (1990) points out how being perceived as sharing the same identity as her subjects presented problems because though she was different to them, she was seen as being the same. The notion of a female researcher conducting research amongst her 'own people' is supported by Soheir Morsy (1988) who provides a recollection of an Arab female's anthropological fieldwork conducted amongst the people of her Egyptian homeland. Furthermore, Morsy (1988) states that recent anthropological

debates have focused on how the identities of anthropologists affect research formulation, data collection and analysis. Anthropology should not dictate the subject of the research or the social identity of the researcher. This is because theoretical progress is not solely based on the denial of the multiplicity of an anthropologist's identities and ideologies, but also through her recognition of different socially-mediated constructions of reality. Conducting research among your own people has its benefits, but as Morsy indicated, the many dimensions of the researcher's identity should not be denied. This has been a weighty issue for me. While I claim that this research is grounded in my personal experience, how similar am I really to the women that I interviewed?

We all identified as coloured women who share the experiences of infertility. Yet despite these similarities, I had to acknowledge the social differences between us as well, because a woman is more than her womb. Morsy (1988) states that even though a researcher may share similarities with her subjects, she is still different to them. Morsy cannot be accused of exploiting Third World culture, but she did conduct her research among people who were less powerful than she was. This issue of power is very important in my research. My position as a researcher placed me in a more powerful social position in relation to my subjects. I hold power because of the resources that I can access. The main difference between the women that I interviewed and me was their immediate desire for a child. I want children at a later stage in my life and at an appropriate time. Also I am able to utilise private, more expensive medical care to address my problems. Most of the informants in contrast had to rely on an overburdened public health system.

Morsy (1988), a native female researcher, states that research conducted within one's society may provide insights reserved for members of that particular society. But there may be disadvantages as well. The following deals with what I perceive as being the disadvantages and advantages of conducting research within my own community.

I have never considered myself privileged before. However, in comparison to the infertile women I interviewed in this study, I had to recognise my relative socio-economic privilege. Some of the participants saw me as economically privileged. For example, Angel would always distinguish between where she lived and the 'nice area' where I lived. Sarah sometimes became defensive about finances, saying that not everyone is as lucky as I am. Veon made me the most aware of my privileged position. She wrote in a journal that I don't realize how lucky I am and that she wished that she could trade places with me, especially in terms of accessing private medical resources. This distinction generated personal guilt that I had to wrestle with throughout the research process.

My guilt about my class position was only one aspect of my research. An advantage of this study was the progressive empowerment of the participants. Through their participation, the women who self-identified as infertile were educated about reproduction and biological indicators of infertility. They were also informed of the availability and cost of treatment in the public and private health sectors. By empowering the participants, the threat of exploiting them was circumvented.

There was also a cathartic aspect to this research, in that the participants could share their pain. Under normal circumstances these women are unable to speak openly about their infertility, due to the stigma attached to it in the communities of the Cape Flats. In the context of the research, the participants could speak freely about their

fears, their hopes and the obstacles they face every day. My identity as an infertile coloured woman was an advantage in this process. Because of our shared identity, the participants felt comfortable about discussing personal issues.

Harding (1987:1) states that between the late 1970s and the 1990s feminist scholars challenged how traditional social sciences methodology analyses women, men and their social surroundings. They have questioned the validity of method, methodology and epistemology and how these could be applied to correct the distorted image presented in traditional analyses. She states that "feminists have argued that traditional theories have been applied in ways that make it difficult to understand women's participation in social life." (Harding, 1987:3). Instead, feminists have produced feminist versions of traditional theories. Thus, the use of feminist methodology is beneficial for this study because in South Africa and Africa, motherhood is still constructed as women's primary identity. There is a dearth of literature on infertility in the African context and this study attempts to fill this gap. Through the use of a renegotiated traditional methodology, this study will examine how infertility impacts on women's lives in order to correct the social and cultural construction that it is a women's problem. It seeks to address how the experience of infertility does not exist in isolation, but exists and intertwines with other cultural and socially-prescribed roles.

The insights from this study are important because they highlight an issue which has been neglected in South African. The public ignorance around infertility has led to infertile women being made invisible or stigmatized. Through this study, these women were able to make their voices heard and contribute to the body of knowledge about infertility.

## **2.4. NEGOTIATING ACCESS**

In the following section, I will address the process through which I gained access to various research sites and recruited participants. I first decided on a sample consisting of young, married infertile women from the Cape Flats, as there is a strong link between aspirations to marriage, motherhood and respectability (in that order) in these communities.

Firstly, a woman only knows whether or not she is fertile when she tries to conceive, which on the Cape Flats, at least ideally, occurs within marriage. There are certain normative expectations that a young woman will remain 'pure' (a virgin) until her twenty-first birthday. Beyond that age, it is expected that a young woman will marry and have children, and respectable motherhood can only occur within marriage.

Secondly, motherhood is a powerful status in the coloured community (Salo, 2004). Pregnancy does not only occur within marriage on the Cape Flats in practice. While motherhood within marriage is ideal in these communities, conception outside the sanctity of marriage is not perceived as socially disastrous as my middle-class biases led me to believe. Motherhood still configures a woman's adult status (Woollett, 1991). After considering the practice of motherhood, I decided to construct a sample consisting of both married and unmarried infertile women.

### **Option 1: Access through the printed media**

Initially I struggled to decide on a means through which I would recruit participants and gaining access to the initial sample of married women proved problematic. A solution suggested itself when I read a letter in the advice column, 'Just Asking Amy' in the 8 March 2006 issue of a widely-read community newspaper, *The Southern*

*Mail*.<sup>10</sup> A young married woman wrote seeking advice about treatment for her infertility. The columnist advised her to seek treatment at her local health clinic, which could refer her to Groote Schuur Hospital's Infertility Department. Her letter was an opportunity for me to access infertile women experiencing the same problem. I viewed this as a valid recruitment option firstly because these newspapers are widely read on the Cape Flats. Secondly, they are distributed at no cost and thus reach a larger portion of the population than paid-for newspapers. I wrote to the columnist on 22 March 2006 (further details in Appendix 1). The letter was published on 5 April 2006 (Figure 2).

**Figure 2. Letter published in community newspapers**

**Dear Amy**  
 I am doing research for a Master's degree in gender studies at UCT. I am looking at the experience of infertility in young women and how it impacts on their daily lives as Cape Flats residents.  
 To do this research successfully I need to meet with young, married women between the ages of 20 and 25. I am particularly interested in meeting the young woman who wrote to you for information on infertility a few weeks ago and any other woman who fit this profile. I can assure my participant of sensitivity and confidentiality with regard to what will be said in interviews. I can be contacted on 084 400 7600 or at 23 Devonshire Road, Orkney 7806.  
 ~Sianne Davids

<sup>10</sup> This 'Agony Aunt' column also appears in other community newspapers on the Cape Flats, for example *The Athlone News*, *the Tatler* and *the Plainsman*.

The first response to my letter was a heartfelt message from Veon: *"Hi Bianca, I just read your letter in the Plainsman. I'm almost 27 years, this is my 2<sup>nd</sup> marriage and I have never fallen pregnant, I'm just so afraid it might become late & it's breaking my heart. I'm sad all the time but I keep praying & hoping, I'm sorry! I realise u asked 4 women aged between 20 & 25 but I also live with the pain everyday. Thanks."* I called her and we agreed that I would contact Veon at a later date for the first interview.

I also received a response from Roxanne who had read my letter in the Athlone News. Although she too did not exactly fit the profile outlined in the letter, she still felt that her story was important. She told me she had had a child seven years ago but had been unable to conceive again.

These responses led to a re-evaluation of the research sample. I decided to include women who were older than the age criteria who self-identified as infertile.

Three days later, I met with Mrs. Williams. She said that for her a baby would fill the boredom of long days at home. She said that people judge childless women unfairly and assume that 'something is wrong with them'. She feels like a failure because she is unable to have a child. She doesn't think the problem lies with her husband, although he is 45 years old. She self-identifies as infertile and said that she has a '*vuil*' (dirty) womb. After three years of unsuccessful conception, she has sought treatment at her local health clinic but there has been no mention of being infertile. She thought that the lack of treatment combined with her youthfulness (she is twenty years old) illustrates the cultural assumptions that young women cannot be infertile. I also established that her desire to conceive was hampered by a lack of information about reproduction and basic reproductive health (For example, when I enquired whether she had had any abnormal Pap smear results, she replied that a woman can

only go for a Pap smear after she has had children). I could not conduct an interview with her later as I was unable to contact her after the initial meeting.

The responses to my letter reinforced my belief that my research would provide women with the opportunity to make their voices heard on an issue that is a daily problem for them. Though unorthodox by positivist standards, this study meets a feminist methodological framework, firstly in that it recognises marginal voices. Secondly, it uses qualitative interview methods to examine women's experiences.

### ***Challenging stereotypes of Motherhood:***

Due to the disappointing response to the letter placed in the Community Newspapers, I reconsidered the initial sample. I had to acknowledge that while motherhood within marriage is preferred, it does occur outside marriage. A new participant also influenced the sample change. Two weeks after the letter was published in the community newspapers, Angel from Mitchell's Plain called. She had read my letter in the Plainsman. She said that she is a forty-year-old unmarried woman who has never had children. As the research sample was supposed to consist of married women only, I re-evaluated the criteria for my sample after encountering Angel. I recognised that in the patriarchal ideals of motherhood, it is culturally and socially constructed that only married women should conceive. But this construct is not as clear-cut in the context of the Cape Flats. Also, as I was arguing that infertility is a stigmatised issue which is shrouded in silence, my sample would inevitably be small. It would be unfair to tell women that they could not be included because they were single.

After the letter in the community papers failed to yield the expected results, I contemplated a new plan to recruit participants through the use of a paid-for



newspaper that is accessible to the majority of the people on the Cape Flats. After considering the newspapers available, I decided to place an advertisement in the Daily Voice – a tabloid widely read on the Cape Flats. It stated: *"looking for women 20-30 who are struggling to fall pregnant to take part in interviews for Masters Research. Will be paid R20.00 per interview. Phone or sms Bianca at 084..."* I e-mailed the copy to the newspaper (further details in Appendix 2). It was published for the first time on 5 July 2006 (Appendix 3).

On the first day of publication, I was contacted by Sarah. She stated that she was an ideal candidate as she had been trying to conceive for about eight years, but was unsure of her eligibility due to her age. After discussion, she agreed to participate in the study. I told her that I did not possess a miracle cure, but could provide advice. After our first interview, it became very difficult to contact Sarah. She subsequently terminated contact.

The following day, I was contacted by William Jones who was making enquiries on behalf of his wife. After discussing logistical issues, he said he would make contact but never did. The fact that he, a man, initiated contact illustrates the importance of childbearing, not only for women, but for men as well.

A woman named Candice enquired about the research and data collection. After explaining that I did not have a miracle cure for infertility or direct access to treatment, we arranged to meet. However, after two unsuccessful meetings, she terminated contact. A woman named Pearl also made contact but failed to arrive for a meeting.

During the two weeks following publication in the Daily Voice, I received numerous phone calls from women who enquired directly about the miracle cure they thought I possessed. They would eagerly describe why they could not conceive, but as soon as they found out that I did not have a miracle cure, their tone would change and they would quickly end the conversation. The perception that I could provide a cure influenced whether or not women maintain contact with me. The numerous responses from women supports my view that infertility certainly exists on the Cape Flats and is the source of pain for many. However, the fact that they were expecting a miracle cure shows that there is a lack of information about reproduction which prevents infertile women from understanding the complexity of their condition.

#### ***Trials and Travesties of telephone technologies:***

In recent years there has been an upsurge in cellular phone usage as a means of communication. The reason for their popularity is cost – it is cheaper to construct cell phone masts than to provide the infrastructure for landline communication. They are also seen as more cost-effective because users can communicate cheaply via SMS (text messaging). As many South Africans make use of this communication tool I decided to use it in my research. In the letter that was published in the community newspapers, my cell phone number was the only means of contact. In our initial interactions, I communicated with participants via text messaging (or sms). They were used to set up meetings, send reminders of times of interviews and to keep in contact with the participants. Through the use of this communication tool, I was able to start building relationships with the participants, as well as keep them interested in the study.

There are also disadvantages to cell phone use. It is easy to filter and avoid phone calls from selected callers, and the low cost of cell phone packages has enabled people to change their numbers easily and often. Thus, it is very easy for someone to become unreachable if they choose to be. For example, I could not conduct even one interview with Mrs Williams as I could not contact her.

Another disadvantage was that the publication of my cell phone number in the Daily Voice meant that I exposed myself to uncomfortable situations, which sometimes provided opportunities for abuse.

### **Option 2: Access via Health sites**

I initially identified public health sites such as primary health care clinics on the Cape Flats as the most probable sites for recruiting participants, as they are the first stop when attempting medical confirmation of infertility. However, this recruitment option was not as successful as anticipated.

#### ***Gaining Access:***

This recruitment process relied on public health professionals working in an overburdened, under-resourced context. To illustrate this point, the South African Institute of Race Relations reported in their survey for 2004-2005 that the ratio of nurses to patients in the public health sector is 1:1224. The ratio of doctors to patients is 1:1435. There are 54 hospitals and 258 primary healthcare clinics in the Western Cape, of which 17 and 108 respectively are in the City of Cape Town district. These facilities provide services to a population of 4 645 000 (South African Institute of Race Relations, 2006).

I arranged a meeting with the director of Manenberg clinic, Mary October<sup>11</sup>. Sister<sup>12</sup> October agreed in principle to my research at the clinic, but instructed me to apply for permission from Dr. Ivan Toms, Director of Health for the City of Cape Town. Two weeks later, I hand-delivered my research proposal to Dr Toms. Accompanying the proposal was a confidentiality agreement (Appendix 5) stipulating the terms between the participants and the researcher, as well as a letter from my research supervisor requesting permission to conduct academic research at Manenberg clinic (Appendix 4). Three weeks after submitting my documentation to the Health Department, I was granted permission by the District Director (Appendix 6). The following week I set up an appointment with Sister October at the clinic to discuss the recruitment process and the anticipated sample size.

I gave Sister October notices to be displayed in the clinic requesting the participation of women between 20 years and 25 years who were struggling to conceive. One version was written in Afrikaans (Appendix 7.1), one in English (Appendix 7.2) and another in a mixture of the two (Appendix 7.3). I also constructed draft lists (Appendix 8) for nurses to note the names and contact details of women who were willing to be interviewed. Sister October said she would not place the notices on notice boards, but would distribute them to the nursing staff. She also cautioned that I might experience problems with implementing this method because many household in Manenberg do not have access to telephones. She suggested that I contact their

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<sup>11</sup> Not her real name.

<sup>12</sup> colloquial term for nurse

'd.o.t.<sup>13</sup> supporters', and offered to discuss the study with these supporters during their next meeting. Sister October also enquired about the incentives I was providing for participation, and mentioned that a previous student researcher had paid participants R15 per interview. She said that people in Manenberg often expect some incentive for participation in research. I decided that informants would be paid for their participation in the study. I will deal further with this issue in the section on ethics.

### ***Language:***

In a meeting with my supervisor, concerns were raised about the suitability of the academic language used in the interview schedules. This had to be reworked into the colloquial language spoken on the Cape Flats. I also had to find the colloquial terminology for certain medical terms. This presented a challenge as it forced me out of my comfort zone of appropriate research language.

After my first meeting with Sister October, it proved difficult to receive feedback from her on the effectiveness of the notices. She was extremely busy and no one else could be of assistance. When I finally managed to speak to her, she advised me to draft a new poster containing basic information. She suggested the wording "*Is jy tussen 20-39 jaar oud? Sukkel jy om swanger te raak? Praat met my. Kontak Bianca Davids: Home- 70... (11:00-17:00) after hours 084...*" [Are you between 20-30 years old? Are you struggling to fall pregnant? Talk to me. Contact Bianca Davids: Home

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<sup>13</sup> D.o.t.: direct observed therapy. These are women in the community who assist the clinic by informing and reminding women when they have their next clinic appointment or when they have to go back for test results. This has been especially effective in the treatment of TB (tuberculosis).

70... (11:00-17:00) after hours 084...]<sup>14</sup> we agreed to meet in two weeks to monitor the interest in the study. During that period she would mention the study to patients at a health talk they have every morning. I made contact after the agreed time only to be informed that Sister October was on leave until 17 July. No one else could be of assistance.

Three months after the Manenberg Clinic programme began, I received a phone call from Aquifa, who had been unable to conceive for eight years. We agreed that I would make contact after confirming the availability of a space at Manenberg clinic to conduct our interviews. After these arrangements were made it was very difficult to contact Aquifa. I conducted my first interview with her on 28 July 2006, in which interesting information emerged, which will be dealt with in later chapters. This was our only meeting.

In the interim I had made contact with the Infertility Clinic at Groote Schuur Hospital. Once again, this form of recruitment was not as successful as anticipated, though this site is of great relevance and importance to my topic, because "Groote Schuur Hospital Infertility Clinic is one of the few tertiary public health institutions in South Africa delivering a reproductive medicine service focusing on the needs of the indigent community." (Dyer, Hoffman, Abrahams 2002:1657).

I was informed that I needed to make contact with Dr Silke Dyer, a director at the Infertility Clinic, who was on leave until 11 July 2006. I made numerous attempts to contact her after this date but she was extremely busy and so unavailable. When I was still unable to make contact by 1 August I no longer saw this facility as a recruitment option. However, I contacted Dr Dyer to discuss infertility treatment options

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<sup>14</sup> Appendix 9.1 and 9.2

available. She was extremely busy and was unable to meet me. Some of my questions about the Infertility Clinic were addressed during a telephonic conversation.

### **Option 3: Social Networks**

I also approached an acquaintance, Desiree, to participate in the study. She was diagnosed with endometriosis ten years ago. Through prior consultation with my personal gynaecologist, I know that endometriosis could be the cause of a woman's inability to conceive. Desiree has not yet been diagnosed as definitely infertile. She self-identifies as infertile. She failed to conceive despite six months of unprotected sexual intercourse in her marriage.

## **2.5. ETHICAL CONSIDERATIONS**

The following section deals with the ethical issues that arose during the research process. Ethical clearance was obtained from the African Gender Institute Ethics committee as well as my research supervisor.

### ***Sensitivity:***

The issue of sensitivity was one of my main concerns. I had to develop an approach that would make participants comfortable enough to divulge sensitive information. My solution was to assure them of the confidentiality of the process, and to tell them my story. By showing that I was open about my own condition I was sending the message that they had nothing to be ashamed of and nothing to fear.

### ***Transparency:***

I informed the participants from the outset that I did not have a miracle cure for their infertile condition. I did not mislead them about what I could and could not offer them. I also made it clear that I could provide advice and that if I did not have answers to their questions, I would try to find answers. Many potential informants dropped out of the research when they learned that I could not offer a solution.

### ***Issues of payment:***

As a feminist researcher, I was very aware of the issue of exploitation. I did not want to use people to gain information in order to authenticate my research question but when done, ditch them without a trace that I was ever there.

I had not been faced with the issue of paying participants before. Would people participate in the research for the money? Would they provide me with truthful responses to my inquiries? Sister October at Manenberg clinic believed that offering this incentive would facilitate contact with informants. After careful consideration, I decided that I would pay informants R20 per interview. However, I was never able to recruit anyone at the clinic. Only one informant, Sarah was the only person paid for her participation.

### ***Making a difference:***

I constantly re-evaluated whether the work I was doing was important. I had been told that it was, but would it really make a difference? I have critiqued researchers as being able to talk about issues, but never translate them into action. However, I had to



accept that making a big difference to how people view infertility on the Cape Flats, and in wider society, would take time. Getting women to talk about their condition was the first step towards greater awareness and eventually demystifying this issue.

As part of the research process, before each interview I discussed various issues with the participants. These included confidentiality, anonymity, the right to terminate the relationship whenever they wanted, and understanding that they were participating on a voluntary basis. Sarah and Aquifa opted to terminate their participation after the research had commenced.

## **2.6. METHODS USED**

This section deals with the methods used to gain the data for this study. I do not seek to draw conclusions from a representative sample of infertile women. I have opted to use grounded methods such as in-depth interviewing and focus groups to gain insight into the experiences of the participants.

This study used qualitative methods. Denzin and Lincoln (2000:8) state that "qualitative researchers stress the socially-constructed nature of reality, the intimate relationships between the researcher and what are studied and situational constraints that shape inquiry... They seek answers to questions that stress how social experience is created and given meaning."

So how and where does gender come into play? Morawski (2001) states that for research methods to be feminist, they should not only take gender seriously, but also acknowledge that there are certain issues, such as the quality of femininity and the experience of unequal gender relations, that are important to women. Not all social

science research methods examine women's experiences of being feminine and of being subjected to unequal power relations with men. Thus not all research methods can be said to be feminist. Many quantitative research methods may examine issues of gender, but such methods cannot reveal the more qualitative experiences of being a gendered person. That is why it is important to match research method and research topic. In a feminist research project such as this, qualitative methods are often more suited to gaining information from research participants.

In terms of researching women's lives in relation to sensitive and important issues such as motherhood and fertility, Miller (2005:7) highlights how "the topic of mothering and motherhood is an area of social research that has greatly benefited from a range of feminist contributions, not least identifying it as an area worth of scrutiny." Earlier feminist research, argument and debate led to the intensive critical examination of mothering. It questioned the social contexts in which motherhood occurred and challenged assumptions of biological determinism that constructed motherhood as compulsory. More recently, other feminist authors such as Inhorn (1996) have theorised motherhood and women's experiences thereof. Yet, others have explored the impact of reproductive technologies on women's lives. (Stansworth) Thus, feminist interpretations of motherhood have continued relevance for contemporary women.

During the planning phase of my research, I had to consider which research methods would be best suited to accessing female informants' experiences and perceptions of infertility. I kept two important considerations in mind. First, as stated before, was the issue of stigma and sensitivity surrounding infertility. I had to choose methods which allowed participants to feel comfortable enough to disclose sensitive and personal

information. For some participants, their participation meant not only overcoming personal inhibitions, but also finally speaking out about their infertility in a context which normally silences them.

The second important consideration was allowing the participants' own voices to be heard. When I met the participants for the first time, I told them that I wanted them to relate their stories, so that I could give them a voice in the academic literature. It could be argued that the participants' voices would be coloured by mine, but I wanted to choose methods which would represent their experiences, albeit through my writing. In so doing, I would create more knowledge about this issue. Reinharz (1992) defines this method as participatory research.

Participatory research differs from other research methods in a number of ways. Both the researcher and the participant decide on the format of the study and the method of data analysis. The participants and the researcher may share the roles of researcher and subject. It is designed to bring about social and individual change because it alters the power relations between researcher and subject.

In feminist participatory research, the power distinctions between the subject and the researcher almost disappear. Reinharz (1992:181) states that "to achieve egalitarian relations, the researcher abandons control and adopts an approach of openness, reciprocity, mutual disclosure and shared risk." Thus, my motivation for conducting interviews with my participants is to highlight women's experiences as women.

After careful consideration, I decided on the following methods:

### ***Interviewing:***

Participants would not be willing to share their stories in a group discussion given the sensitivity of the topic. I selected to conduct individual interviews with participants to provide them with the opportunity to tell their story in a secure, non-threatening environment.

Interviewing can set up an unequal power relationship between interviewer and interviewee. Anne Oakley (1981) challenges traditional interviewing; stating that there was a gap between her own experience of interviewing women and the textbook criteria for conducting interviewing. Traditional interview criteria state that interviewing is a one-way process in which the interviewer only elicits information from the interviewee. Here, interviewers see their participants simply as sources of information. Interviews also often fail to give meaning to the context in which they occur. These traditional perspectives are problematic for feminist researchers whose main objective is to highlight women's experience as women, while challenging power relations in traditional research. Oakley (1981:31) argues that "social science researchers' awareness of those aspects of interviewing which are 'legitimate' and 'illegitimate' from the viewpoint of inclusion in research reports reflects their embeddedness in a particular research protocol. This protocol assumes a predominantly masculine model of sociology and society." Thus, there needs to be a shift from the masculine bias of dominant social science methodological system research methods.

Oakley (1981:41) states that when a feminist researcher interviews another woman, it has to be recognised that that use of prescribed interviewing practice is morally indefensible because it reinforces a power hierarchy between interviewer and

interviewee. She says that the main objective of interviewing is to find out more about people, and this is best achieved through a non-hierarchical relationship between the interviewer and the interviewee.

The application of Oakley's interviewing principles in this study proved to be very successful indeed. The participants shared their experiences with me and I shared mine with them. They often asked me questions to which I would reply as truthfully as possible. This reciprocal relationship was also assisted by conducting the interviews in the language with which the participants felt most comfortable, English, Afrikaans or a mixture of the two languages.

The research process consisted of interviews conducted over seven months between April and November 2006. It was divided into four themes around which interviews were conducted. Interview one focused on the participant's life history. Interview two examined their access to resources for medical visits. Interview three focused on their perceptions of infertility, and interview four on the meanings of motherhood. All four interviews were conducted with Desiree, Veon, Angel and Roxanne. Interviews one and two were conducted with Sarah before she terminated her participation. Only the first interview was conducted with Aquifa.

Further interviews were also conducted to enrich information obtained through the formal interview schedules. Interviews were recorded and later transcribed. Further information was sought in follow-up interviews. I upheld the terms of the confidentiality agreement by personally transcribing and translating interviews.

During the follow-up interviews the participants had the opportunity to review the data gathered during their previous session and clear up any related issues. The formal and follow-up interviews were also supplemented by 'informal' interviews especially

if a participant wanted to share a certain experience which they considered important in constructing their story such as for example, Veon's experience of her miscarriage. In total, I conducted thirty-two interviews.

The structured interviews had varied results. I prepared structured interview schedules containing themes which I felt were important to the study. Sometimes participants would give terse, short responses to questions, or not respond at all. It was an advantage to have the questions, as they gave the conversations a starting point, allowing informants to speak at length later questions.

During the interviews, I observed that some participants had set boundaries about what information they would share. For example, Roxanne spoke predominantly about her infertility treatment and her role as mother. To the other questions she would give brief answers, or simply say "I don't know." Other participants used the interviews as a means to speak openly about their experiences with infertility. Veon, Angel and Desiree all shared information freely and comfortably.

#### ***Focus Group:***

Given the sensitivity of the topic I decided not to use focus group discussions to elicit information. However, I wanted to emulate Inhorn's study by including the perceptions of fertile women, to understand how infertility is constructed in the communities of the Cape Flats. Inhorn (1996) argues that it is important to include fertile women's perceptions, not only for comparative purposes, but also to show the meanings of motherhood within a particular society. This was the justification for using a focus group to gain this information.

Focus groups are used within qualitative research as a means of engaging with a group of individuals about a given topic. Thus, they are most appropriate when the researcher wants to explore a topic using group dynamics, where interpersonal relations are important to the research. Like other qualitative methods, focus groups require the full attention of the researcher and the understanding of the participants regarding their context, particularly in relation to the research. According to Kitzinger and Barbour (1999), focus groups are a qualitative method in which group discussion ensues. Morgan (1997) states that focus groups rely on data from the whole group and not just an individual or set of individuals. The researcher's role in the process is to be attentive at all times and to promote conversation among the group by asking open-ended questions as well as facilitating friendly group dynamics. Furthermore, Kitzinger and Barbour (1999) state that focus groups are ideal for revealing a group's attitude or perception towards a certain topic; moreover, they are best used when observing the construction and expression of that perception.

I also conducted a focus group that included four women from Tafelsig, who had borne children. They were:

1. Anne, a 59-year-old, Afrikaans-speaking, unemployed, coloured woman, with a grade six education. She is widowed. Anne has eight children, twelve grandchildren and one great-grandchild.
2. Eileen, a 53-year-old English-speaking unemployed, coloured woman with a grade seven education. She is a widow. Eileen has six children and eight grandchildren.

3. Snoopy, a 32-year-old English-speaking, unemployed coloured woman, with a grade nine education. She is a widow. Snoopy is Eileen's eldest daughter, and mother to four children herself.
4. Meagan, a 23-year-old Afrikaans-speaking, unemployed coloured woman with a grade seven education. She has been with her partner for eight years and is engaged to be married. She has two daughters.

### ***Journals/Diaries:***

In addition I also requested my main informants to keep a daily journal in which they could express intensely personal feelings and experiences on infertility. I know that writing about one's feelings and experiences is very therapeutic. Diaries also facilitate access to personal or intimate information that might not emerge in face-to-face interviews. Supporting the validity of this method, Willing (2001:28) states that "when used successfully, the diary method of data collection can provide access to information that is otherwise very hard to obtain. The data is temporally ordered; that is, it reveals how events unfold prospectively in real time." Diaries eliminate inaccurate retrospective reporting, that can be coloured by participant's present circumstances or forgetfulness.

I had varying results with this method. I distributed six journals to the informants. Sarah and Aquifa terminated their participation without returning their journals. Initially, Angel told me that she would try to write, but after interview three, she informed me that she was no longer planning on doing the task. Roxanne, Desiree and Veon all maintained journals that returned filled with rich detail.



### ***Time schedules (and participants' failure to follow them):***

I planned to spend time with participants at their homes, or in any space where they felt free to talk. This would assist me in gaining access to detailed information. This plan failed because most participants were all full-time employees and unable to meet me at their homes. I had to work around their schedules and conduct interviews when it was most suitable for them. In most cases, the only time that we could conduct interviews was on Saturdays, when the participants could spare some time. I was unable to spend 'informal' time at their homes or to 'eavesdrop' on sensitive topics such as how infertility was affecting the women's relationships with their partners. This was time for Sarah and Desiree, whose interviews were conducted at their workplace. I interviewed Roxanne at her home on Saturday afternoons. Similarly, Aquifa was also interviewed at her home. While I was unable to conduct interviews at Veon's home, we spent a lot of informal time together at my home and we became close friends. I did have the opportunity to gain some insight into Angel's life, during my Saturday afternoons at her home. I met some of her friends and even witnessed a public quarrel between Angel and her neighbour.

### ***Fertility Risk Test***

During the first stages of my fieldwork, participants were asked to complete a fertility risk quiz for women. The test was adapted from the book *The Fertility Handbook: A positive and practical guide* (1986) by Joseph Bellina and Josleen Wilson. The authors state that this test can give individual women an idea of what their chances are of having a reproductive problem. The test is routinely given to infertile women by fertility specialist and is considered 85% accurate. I made the participants aware that when identifying the causes of a woman's infertility, these are the sort of questions

asked by doctors and fertility specialists. While this is a test employed in the biomedical field, the book containing this test was sourced from a public library. Clearly this information is easily accessible to the educated layperson, and the test was easily understood by most of the informants. The questions were straightforward and most questions did not need clarification, though it was provided where necessary. For example, three of the women did not know what Gonorrhoea was. This was explained, which led to a discussion on whether they had contracted any other Sexually Transmitted Diseases (STD) and if they knew how this might affect their fertility. To simplify matters even more, the test was conducted in the participants' language of choice. The only problem that I foresaw was that some women would not know what an Intra-Uterine Device (IUD) was. To circumvent this, I included the colloquial term 'the loop'. The tests were conducted with the participants' permission. I had two reasons for including this test. Firstly, it provided me with easy access to the history of possible problems. Secondly, I wanted to give the participants some insight into the biological complexity of fertility, and obtain information from them about the process they may have gone through to identify infertility as a problem, and about their search for advice. In Chapter Three I explore the content of and reasoning behind the questions asked in the test.

### **Conclusion:**

The stigma attached to publicly being known as infertile combined with the veil of silence surrounding infertility on the Cape Flats had a profound impact on the research process. It raised methodological issues which led to a re-evaluation of certain aspects of this study. I anticipated that it would be difficult to recruit participants. However, I did not expect that the process would be severely hampered

by women's reluctance to talk to an outsider about such a personal issue, as well as by the severity of the silence surrounding the issue. I did not have direct access to a readily-identifiable research sample. I had to use creative recruitment methods such as snowball sampling, and a published a letter in community newspapers, as well as relying on nursing staff for recruitment of participants. Finally, I recruited a sample of six coloured women ranging from the age of twenty-two to forty years old, and residing in different areas on the Cape Flats including Surrey Estate, Hazendal, Manenberg, Tafelsig, Mitchell's Plain and Grassy Park. More women responded than those who were selected. Most respondents eventually declined to participate, when they learned I could not provide them with immediate solutions to infertility.

This study was with six women who have self-identified as infertile. This self-identification may not satisfy the bio-medical definition of infertility, but these women's perception that they are infertile is in accordance with the social and cultural understanding of infertility in their communities. Their definitions of infertility might not be accurate, but they are important nevertheless, because they provide us with some insights into local constructions of infertility.

Anthropological and feminist methodologies were used to collect data. Methods include in-depth interviewing, journaling, participant observation, a focus group and a laypersons' fertility risk test. The bulk of the information used was gathered through the thirty-two interviews conducted, as well as from the journals kept by some of the women. This study enabled women to relate their stories and experiences of dealing with infertility whilst allowing me to share my own experiences with them. The study also posed challenging ethical questions such as payment for participation which had to be addressed.

In the following chapter, I will delve deeper into the identities of the participants. I present the bio-medical definition of infertility as well as the biological causes of infertility. I will compare and contrast these with the participants' understanding of the causes of their infertility. I also examine the cultural factors that influence these women's understanding of their infertility.

University of Cape Town

## CHAPTER 3: SEARCHING FOR ANSWERS

Infertility is commonly seen as a uniquely bio-medical problem, especially among health professionals and educated South Africans. It is an 'unlucky' quirk of natural biology. However, the gasps of disappointment and sympathetic cries that greet the news of one's infertility confirm that it has cultural meaning. They suggest that infertile women are perceived as being unable to fulfil their primary social duties as mothers and that they are therefore incomplete persons. Infertility also has gendered implications, because it is viewed as a woman's problem. Most often it is women, not men, who seek treatment for infertility.

### *Defining infertility:*

The women who participated in this study all defined themselves as infertile. While it is unknown to what extent they are correct and what the true cause of some of the women's infertility is, though there has been no bio-medical diagnosis, the participants (and their communities) perceive themselves as infertile. Given this social and cultural perception, it is still not clear whether there is some connection between the participants' definition of infertility and how infertility is bio-medically defined. Does bio-medicine define infertility simply as the biological inability to bear a child? What is the difference between primary and secondary infertility? Just the process of posing these questions indicates that socially and culturally they are practically irrelevant. The 'infertile' label, in the communities of the Cape Flats, is not dependent on bio-medical definitions of primary and secondary infertility, but simply on a woman's ability or inability to conform to the motherhood mandate.

It is commonly understood that infertility exists or is confirmed when a women is unable to conceive after a year of unprotected intercourse. Thus, it's important to have a basic understanding of what this 'infertility' means. Boerma and Mgalla (2005:14) provide a good answer. They define infertility primarily in biological terms as the "inability to produce a live birth. This term captures the inability to conceive, impregnate or carry a pregnancy to term and live birth. Women who conceive but have subsequent abortions (pregnancy wastage) are considered infertile, just as women who are unable to conceive. In medical discourse, distinction is made between primary (has never been pregnant) and secondary infertility (cannot give birth following at least one live birth)." Thus, infertility is not only the inability to conceive but also the inability to give birth to a live child.

Roxanne's case can be used to illustrate this point. After a year of unprotected intercourse during her marriage, she was still unable to conceive. She sought medical intervention and was diagnosed with Poli-Cystic Ovarian Disease (PCOD). Symptoms of this condition include excessive facial and body hair, obesity, infertility and irregular menstruation even after the onset of puberty at the expected age. Women who suffer from this condition cannot predict when or how long they will menstruate or the severity of the menstrual flow. Fertility problems occur as although the ovaries become thickened and the ovarian follicles start maturing, the eggs are rarely released. Reinisch and Beasley (1990:411) state "the hormonal level of women with PCOD does not fluctuate in the usual cyclic monthly pattern. The problem seems to result when the pituitary gland and the hypothalamus (the part of the brain involved in reproductive functioning) receive inappropriate signals about existing hormones such as androgens (which stimulate facial hair growth) and do not produce enough of some other hormones such as FSH (which chemically signals release of eggs from the

ovaries)." After seven years, Roxanne conceived and gave birth to her son. She has been unable to conceive again. It seems that she has suffered from both primary and secondary infertility. However, it is important to note that she does not make these finer distinctions. She defines herself as infertile despite having borne a child.

Desiree was diagnosed with endometriosis but not as infertile. Moore and Zimbizi (1996) explain this condition. Normally the endometrium, which is the lining of the womb, detaches itself and is expelled as blood during menstruation. When a woman has endometriosis, tissue that reacts like the endometrium is found in locations other than the womb. Moore and Zimbizi (1996:418) state that people refer to it as "normal tissue in an abnormal location." Growths commonly appear on the ovaries or Fallopian tubes but can also attach themselves to other vital organs or other areas of the body. The tissue that grows outside the womb responds to the menstrual cycle but is not expelled as normal endometrial tissue. Instead this tissue bleeds internally, causing inflammation and cysts. This is a very painful condition. Moore and Zimbizi (1996:418) state that women who suffer from endometriosis may experience "pain during menstruation or sexual activity; tiredness, lower back pain, painful bowel movements during periods; diarrhoea and constipation during periods, and infertility." While endometriosis can be a cause of infertility, it is not known whether a woman is infertile until she tries to conceive and is unable to do so. Thus, as with the other participants, Desiree has not been medically diagnosed as infertile but self-identifies as such.

Bio-medicine identifies infertility in terms of reproductive problems, but has failed to acknowledge the cultural definitions and implications of infertility. This study goes

some way towards addressing this knowledge gap and, the wider implications including stigma and the gendered aspect of suffering.

In this chapter, I will present the profiles of the participants. This will serve to familiarise the reader with the women who participated in this study. I will also examine how the women identified their problem of infertility. I will then present the quality of the sex education they received from adults such as their mothers. I will show how the participants and I gained some insight into the possible medical causes of their infertility by using a popular medical survey on reproduction. This chapter will conclude by presenting one woman's experience of being diagnosed by a private gynaecologist.

### **3.1 INFERTILE WOMEN**

As stated before, all my informants perceive themselves as suffering from infertility, whilst one who medically diagnosed as such. Even though they share the commonality of infertility they have different lived experiences of this condition. This includes photographs of the participants<sup>15</sup> with their permission.

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<sup>15</sup> Figure 3 to Figure 6



### **3.1.1 Roxanne**

Roxanne is a 35-year-old woman living in Surrey Estate. She has two older sisters, two younger sisters and a younger brother. She describes herself as an English-speaking Indian woman. Her highest level of education is Grade 12. Roxanne is employed as a receptionist at a family firm. Roxanne was married when she was 21 years old and has been happily married for 14 years. Apart from her infertility, Roxanne describes her health as excellent. When she first sought medical intervention for irregular periods when she was nineteen years old, she was told only that she had 'a problem with her ovaries'. As a result, she suspected that she might have problems conceiving. After a year of marriage and unprotected intercourse, she realised she might be infertile. During this time she discussed the issue with her mother, who advised her to accept her infertility and not to question God's will. She also discussed her fears with her husband. He assured her that she would be able to conceive. Dissatisfied with these responses, she sought treatment at the Infertility Clinic at Groote Schuur Hospital. Here she was diagnosed with Poli-Cystic Ovarian Disease (PCOD). She was told that it was a very common condition that does not affect a woman's lifestyle except when she is trying to conceive.

After five years, in 1998, Roxanne finally conceived and carried a pregnancy to full term. Since the birth of her son seven years ago, she has not had any other menstrual problems apart from her irregular periods. She uses prescribed medication monthly to ensure ovulation. But PCOD is hampering Roxanne's chances of conceiving again. Excessive weight gain is one of the symptoms of this condition, and Roxanne has been told that she will only be eligible for treatment at the Infertility Clinic if she loses 10 to 15 kilograms. She has begun on a weight-loss programme but has found it very difficult.

Roxanne, who is of Asian/Indian descent, is the only participant suffering from secondary infertility. Though she has a son, the societal powers that influence infertile women still affect her, especially in the context in which she lives. She states that Indian men want many children, and the Indian community expects women to conform to this requirement. She however is not able to conform to this expectation.

### **3.1.2 Desiree**

Desiree is a 40-year-old woman living in Grassy Park. She is the eldest child and only daughter in her family. She has a younger brother. Desiree describes herself as a coloured woman, who is bilingual. Her highest level of education is Grade 12. She is currently employed as senior office manager at a university in the Western Cape.

**Figure 3: Veon**



**Figure 4: Desiree**



**Figure 5: Roxanne**



**Figure 6: Angel**



Desiree has been married for a year but is currently seeking a divorce. Previously Desiree was not concerned about having children, but since her marriage, conception and childbearing have become important. Her preoccupation bears out the cultural expectation for women that children will 'naturally' follow after marriage.

Apart from her infertility, she describes her health as good. She sought medical treatment ten years ago for unbearable abdominal pain and excessive menstrual bleeding. She was told to bear a child and then return to have a hysterectomy performed. The gynaecologist she saw also prescribed the contraceptive pill. Desiree used the pill for two months, but says that by the third month she was debilitated by excruciating pain. She consulted a second gynaecologist, who diagnosed her as suffering from endometriosis. She had surgery to remove a growth from her ovaries. Desiree has not been medically diagnosed as infertile but self-identifies as such as she has been trying to conceive for a year without success. Her perception that she is infertile is also informed by her age and the fact that endometriosis hampers conception. She feels no urgency to access infertility treatment even though she knows that it is available. She has educated herself on every imaginable issue relating to reproduction through independent research. She says that she will not be forced to seek treatment and she has made peace with the possibility that she will never have children.

### **3.1.3 Angel**

Angel is a 40-year-old woman living in Tafelsig, Mitchell's Plain. She has three older brothers and a sister. She is an Afrikaans-speaking Coloured woman. Her highest level of education is Grade Nine. For the past twenty years she has been employed as an operator at an industrial factory.

Angel is unmarried but has been in a short-term relationship for the past ten months. Since she became sexually active at the age of 22 years she has had unprotected sex in her relationships, but has never conceived, even though she was willing to accept conception if it happened. After six months of unprotected sexual intercourse in her first relationship, she realised that she might be infertile. She discussed the possibility with her partner. The couple decided to take a 'wait and see' attitude and did not attempt to seek medical assistance. Her partner was very supportive but the couple separated a few years later. To date Angel has not sought medical treatment, though she says she knows there is something wrong with her, she has no medical proof of this suspicion apart from her obvious inability to conceive. She also states that she has no physical symptoms that indicate a problem.

#### **3.1.4 Aquifa**

Aquifa is a 23-year-old woman living in Manenberg. She has four older brothers and a younger sister. She describes herself as an Afrikaans-speaking Coloured woman. Her highest educational level is Grade Ten (Standard Eight). She left school to seek employment out of financial necessity. She has worked as a receptionist at a local spice company for the past two years.

Aquifa has been with her current partner for eight years and has been married for the past two years. She has been sexually active since she was 15 years old. Apart from her infertility, Aquifa describes her health as good. She informed me that she has been trying to conceive for the past eight years. The pressure to conceive has increased since her marriage. She has not been diagnosed by a medical practitioner. She says that her inability to conceive during eight years of unprotected intercourse indicates that she may be infertile. She first suspected that this might be the case after a few

months of having unprotected sex. Previously she had assumed that she would conceive soon after becoming sexually active because this had happened to most of her friends. She did not discuss her suspicions with anyone, and clung to the belief that because she was young, she would conceive. However, now she has realised that she needs medical advice. Her decision to seek treatment was taken after her husband's insistence that she do so. He was supposed to accompany her to her medical consultation but they then decided not to consult a doctor after all. She has no idea of the possible cause of her infertility.

### **3.1.5 Sarah**

Sarah is a 33-year-old woman living in Hazendal. She is her parents' eldest daughter and has two younger sisters. Sarah describes herself as Coloured woman, with Afrikaans and English as home languages. Her highest level of education is Grade Eleven. She is employed as an emergency control-room operator by a Cape Town-based security firm.

Sarah has been with her current partner for ten years, and married for the last year. The couple have been trying to conceive since Sarah was 25 years old. During this time, she has not sought medical treatment. Sarah realised that she might be infertile after the first year of trying to conceive. Apart from her infertility, she describes her health as good. She said that I was the first person with whom she has discussed her inability to conceive.

### **3.1.6 Veon**

Veon is a 27-year-old woman living in Tafelsig, Mitchell's Plain. She has three older sisters and two older brothers. She describes herself as a Coloured woman who is

bilingual. Her highest level of education is Grade 12. She has been employed as a data capturer since September 2006. Veon's case will be dealt with in further detail later in this chapter.

### **3.2 SOCIAL PRESSURE TO ATTAIN MOTHERHOOD**

All these informants said that they experience immense pressure to become mothers. This pressure causes them to feel that it is necessary to seek infertility treatments. But the expectation that motherhood is natural creates difficulties for women who seek diagnosis and treatment for infertility. Women are blamed for infertility even though they seek solutions, and unequal gender relations exacerbate their suffering.

Women in a relationship (and even more so when married) are often asked by friends and family when they are having a baby, a question most infertile women hate.

Though some questions may be innocent, the failure to conceive publicly point out that the couple is unable to conceive on their own. My informants all agreed that people who ask this question don't realise the stress that these women experience in their quest to conceive. Sister October said that she suffered from infertility when she was first married. She and her husband were often asked "*Nou wanneer dan?*" (Now when will you have a child?). She was married for almost three years before conceiving her first child. She remembers those three years before her son's birth as being a stressful period. Every time she went to visit in her in-laws, they would ask her when she was going to have a baby.

All these women said that they often receive advice from friends and family about falling pregnant, ranging from the practical to the bizarre. Sarah was told not to urinate after sex. She was also told that her husband should put a cold cloth over his

testicles before intercourse. She has not tried any of the recommended methods.

Similarly, Roxanne has been given numerous suggestions on what to do by friends and family, but seldom used the advice that she was given.

However, not all women are subjected to this advice. Veon, Desiree and Angel have never received advice from friends and family on what to do to aid conception.

### **3.3. IDENTIFYING THE PROBLEM**

This section deals with the cultural taboo that surrounds openly discussing sexual or any related matters in the communities of the Cape Flats, which affects infertile women's treatment-seeking behaviour in that they are unable to publicly discuss sexual or any other related reproductive issue for fear of judgment from their communities.

On the Cape Flats, there is an unspoken rule that men and women will only have access to sexual information when they reach adulthood, or when circumstances necessitate it (Salo, 2004). Under normal circumstances, information on sexual issues is only shared with younger men and women who are adult and only when older members of society deem it appropriate. However, this information only relates to appropriate sexual behaviour; there is almost total ignorance of biological information on reproduction to assist women to understand their reproductive system. The consequence for women, and more specifically infertile women, is that they are unable to recognise identify normal or abnormal processes for the female body. Infertile women cannot be expected to identify their problem if they are not educated in reproductive health. As this chapter will show, the biological indicators that hint at possible causes of a woman's infertility may be present, but given these women's



ignorance, they are unable to seek adequate treatment. This lack of knowledge is not only restricted to infertile women on the Cape Flats. In most South African communities there is a compulsory cultural prescription that prohibits young women from accessing information on sexual matters until they are preparing for marriage and ready for motherhood.

This also leads to the perception that women should not be recognized as sexual beings. In the communities of the Cape Flats, sex is not seen as an act of pleasure but solely for procreation. Consequently, women's sexuality is silenced, often denied. These women to educating themselves on the finer points of female sexuality and reproduction are not 'allowed'. The expectation that women will be mothers, combined with the taboo on open discussion about sex, leaves infertile women struggling with their suspicion about infertility on their own.

These women's awareness of infertility occurs over time, often after a period of unprotected sexual intercourse. Significantly, though all but one of the women were adolescents when they tried to conceive. Five of the informants were adolescents; even as young as fifteen, when they began to suspect they were infertile. Roxanne, Veon, Angel, Aquifa and Sarah were in their late teens to early twenties when they began trying to conceive. Thus, it could be said that while infertility has only become an issue later in these women's lives, it is an issue that began in their youth.

The women's inability to access adequate medical treatment could be ascribed to two widespread societal assumptions – firstly, that young women should not have reproductive problems, and more significantly, that they should not attempt to become parents. This is a double taboo. Teenage pregnancies are constructed as a social problem, so teenage women are not expected to be sexually active, let alone desire

parenthood. This is illustrated by the state health services making contraceptive services freely available to young women between the ages of 15 and 24 to prevent early parenting. There is no focus on providing infertility treatment to this age group. In a society such as ours that constructs young, unmarried women's fertility as a problem, when a young woman suspects she may be infertile, she might hide it, either in a bid to prevent being seen as abnormal, or to hide the fact that she is able to engage in 'illicit' sex without the consequence of pregnancy. Thus, the age at which a woman realises she may be infertile also informs her ability to identify the condition of infertility.

### **3.3.1 Education about reproduction: Biology or Social Norms?**

All these women said that they discussed sex and reproduction with their mothers. These discussions it seems, enforces social taboos about knowledge about social sexuality, rather than educating the women about biological processes *per se*. All the women were told that they were now young ladies and had to take care of themselves. The information is passed on to the participants after first menstruation but focused more on appropriate gender behaviour.

I found most of the participants lacked basic biological information about the female body and reproduction. This ignorance often prevented them from seeking medical assistance. Roxanne was the exception - she had acquired extensive biological knowledge on reproduction, through extensive reading, and later through visits to medical practitioners and the Infertility Clinic at Groote Schuur Hospital. All the other participants delayed seeking medical treatment because they said they lacked sufficient knowledge about their menstrual cycles. This became clear during the interviews. For example, when I asked Angel why she did not worry about suffering

from irregular periods for most of her life, she responded that it was something that she has learned to accept. Women come to 'accept' medical problems that they do not understand. Even though Angel knows where babies come from, at the age of forty years, she has only rudimentary knowledge about human reproduction. She stated that both women and men have sperm. Similarly, Sarah also lacked knowledge of women's normal reproductive cycle. This lack of knowledge was clearly detrimental to these women, as it prevented them from identifying the cause of a possible reproductive problem early on.

Moore and Zimbizi (1996) state it is important that women know what is normal for their bodies, so that they can be aware of changes and abnormalities. They like other researchers argue that the female reproductive health system is fragile and needs constant monitoring. Education on reproductive health is important for women, as many reproductive health problems are not easily recognised and diagnosed because the symptoms are difficult to pinpoint. Thus, if a woman is unable to recognize changes in her menstrual or reproductive cycle, she is unlikely to be able to identify the possible symptoms that could identify the causes of her infertility.

So what type of sexual education did these women receive, and did it include the biology of reproduction?

### **3.3.2. Sexual education and social relations**

When questioned about the sex education they had received, it became clear that the participants had been socialised into acceptance of the gender and generational taboos surrounding sexual behaviour and communication. They said that when they began menstruating, they were only able to talk to older women about it, most often their

mothers. Angel started menstruating when she was thirteen years old. Her mother told her that she was a '*jong meisie*' (a young woman) and that she should 'take care of herself'. Her mother warned her not to fool around with boys because she could now 'fall' pregnant. Even though Angel's mother never discussed menstruation with her daughter, Angel said she knew what she needed to know because she had discussed it with friends. She said that her mother never discussed sexual matters with her children.

The information the participants did receive from their mothers focused mainly on the increase in physical gender separation that they said was necessary after menstruation. In most cases, the women were told to stay away from boys or that they should not allow boys to touch them. However, what type of physical contact to be avoided was not clearly indicated. They also received social education on appropriate gender behaviour as illustrated in Aquifa's case below. The use of vague language also illustrates the prohibited nature of discussion on sexual matters.

After Aquifa began menstruating at twelve years, her mother's spoke to her only about appropriate sexual behaviour. Her mother told her that she that she should wait before she 'took that step' (i.e. to be sexually active). She was told not to 'vry' (fool around) with young men because it could lead to sex. Her mother did not discuss the matter further with her. Aquifa said that at age fifteen her mother noticed that her body was changing, and asked her whether she was sexually active. When she replied in the affirmative, her mother's response was that sex could lead to pregnancy and that she was too young to bear children. However, Aquifa's mother did not advise her how to use contraceptives, and the topic was never raised again. Aquifa said that she was

informed about the intricacies of sexual intercourse mainly by friends who were older.

All the women stated that they were unable to discuss sexuality with their fathers or other males. This illustrates that there is a gender taboo on the gender and sexual socialisation of young women that limits their sources of information. As a pre-pubescent, Sarah had received no biological information about menstruation. She did not know what changes she would experience during adolescence. When she started menstruating at thirteen, she thought that she was dying. She had just used the toilet and when she wiped herself, she noticed blood on the toilet paper. She started crying but thought that if she waited long enough, the bleeding would stop. She became panic-stricken when it did not. Her mother had never spoken to her about menstruation. Eventually she told her father about her discovery, and he told her that her mother would speak to her when she arrived home from work that evening. Her grandmother was visiting that evening and told Sarah that she must not allow boys to touch her. Sarah does not blame her mother for not informing her about menstruation. Her mother was a working mom and did not have time to discuss these matters with her daughter. Sarah feels her ignorance was encouraged because all parents want their daughters to remain innocent.

Sarah did not receive any education on the biological aspects of reproduction at school or from her parents. When she started dating, her parents assumed that she knew what to expect and how to behave in relation to boys. Their active avoidance of discussion on sexual issues illustrates the social taboo associated with talking about sex across the generational divide. Sarah's parents' failure to discuss sexuality with her contributed to her ignorance about the biology of sex. After she began menstruating,

Sarah's grandmother told her that if boys touched her she would conceive. While she was sitting in class at school one day, a boy's leg accidentally brushed against hers as he was sitting down. She jumped out of the desk and shouted that the boy had impregnated her. Sarah's ignorance about reproduction persisted even after she became sexually active when she was 19 years old. At that time she was dating a young man from her community. When he took off his sweater on a visit to the beach, she noticed that he had a large tattoo on his back. She started crying, saying that if they had to have a baby, their child would display the tattoo too.

All the women said that the information they received after first menstruation focused on appropriate gender behaviour. They were told that they had become young ladies and had to 'take care of themselves'. When Veon started menstruating, she said that she knew exactly what was happening to her body because her mother spoke to her frankly about this. Other women in the community negated this frankness. Veon's maternal aunt frowned upon her open discussion with her mother and reinforced the social taboo on openly discussing sex. Veon's mother however persisted. She advised Veon not to use tampons and to dress warmly because '*Jou niere gan koud kry. As djy nie luister nie, djy gan een dag spyt wies*' (Your kidneys will get cold. If you do not listen now, you will regret it one day). She was advised to bath three times a day or at least every time she changed a sanitary pad. She was told to check her flow regularly so that she would know how heavy it was. Veon's maternal aunt instead provided her with quaint, irrelevant. This included advice that she should not ride a bicycle or spread her legs widely when she sat down.

Some of the participants noted that their socialisation about appropriate sexual behaviour was not only their mother's responsibility but the responsibility of all older

women in the community. Aquifa had a woman high-school teacher who discussed sexual issues with her students. These 'talks' focused on sexually appropriate behaviour. Little attention was paid to educating the students about the biology of reproduction. The teacher told her students that when they have their periods, they should not allow a man to touch them because men would perceive them as sexually mature. Most men would tease and touch these girls in intimate places and as a result they could fall pregnant. Once again, it can be observed that vague language and not specific terms are used to refer to the act of sex. This vagueness reinforces the taboo on openly discussing sex with minors. The teacher did not discuss birth control or condom use with her students.

All this information suggests that a highly gendered folk system of sexual education exists which focuses strongly on the taboos about sex and gender separation and interaction that exist on the Cape Flats. The information that these women received indicate that the older women educated them about gender appropriate behaviour and reinforced taboos about discussions on sex.

### **3.3.3 Fertility Risk Test: factors that contribute to infertility**

A medical diagnosis of infertility is hampered by a lack of the women's' information on the biology of reproduction, which is the result of inappropriate sexual education for women on the Cape Flats.

Despite all the women reporting that they self-identified as infertile, only Roxanne sought medical confirmation and was diagnosed as infertile. Desiree has not been medically diagnosed as infertile. She knew that one of the side-effects of

endometriosis is infertility. In a bid to identify the participants' infertility problems, they were asked to complete a fertility risk quiz for women.

In Interview 1, participants answered questions about their personal medical history. This information supplemented the information gathered in the fertility quiz. Bellina and Wilson (1986) state that there are four areas that are most revealing in establishing the cause of a woman's infertility.

1. Menstrual history. When consulting a doctor or fertility specialist, the patient is asked in-depth questions about her menstrual history in order to reveal hormonal imbalances. Normal menstruation goes through an oestrogen and a progesterone phase. Bellina and Wilson (1986) state that the latter phase signals ovulation, and when a woman does not feel any changes before or during her menstrual cycle, it is possible that she is not ovulating.

2. In questions about sexual history three questions are crucial. Firstly, at what age did the patient become sexually active? The rationalisation is that women who become sexually active at a young age are more susceptible to contracting pelvic infections. This may occur without the woman even knowing about it. Secondly, the number of sexual partners she has had to date indicates her exposure to the risk of contracting a venereal disease or pelvic infection. Thirdly, a patient will be asked to what type of sexual encounters she has had. (Bellina and Wilson 1986). I did not ask this question because I thought that it was too personal.

3. Infections. Pelvic Inflammatory Disease (PID) is the most significant infertility-causing disease. The patient is usually asked if she has been hospitalised for a pelvic infection, or if it has previously been suggested that she has had such an infection. She



will also be asked if antibiotics were prescribed for the infection. "A problem severe enough to require antibiotic treatment is a strong clue that some mechanical problem now exists inside the pelvic area." (Bellina and Wilson, 1986:124).

4. Contraceptive history. A patient will be asked whether or not she has previously used contraceptives, and for what length of time. If a woman has used contraceptives but has had frequent sexual intercourse since discontinuing use, she should be able to conceive naturally. However, some contraceptives have a negative impact on fertility. The two most problematic are oral contraceptives and the Intra-Uterine Device (IUD). Women who have used oral contraceptives for many years require several months before their normal hormonal patterns are re-established. IUDs can puncture the uterus, which could cause infection. Because of these potential problems, the participants were asked whether they had used either method (Bellina and Wilson 1986).

In the following section I will present information I obtained from Angle, using the survey above. Her case illustrates the factors that are taken into consideration when diagnosing a woman as infertile.

Angel has suffered from irregular periods since she started menstruating at age thirteen. A few years ago, she consulted her doctor about this problem and was informed that she was starting menopause. As she was only 40 years old she thought that she was too young to be menopausal. Angel has not returned for confirmation and has accepted that she has a short, irregular cycle. She says that she does not like consulting her doctor. She only visits her doctor in order to obtain a medical certificate she needs to take sick leave from work.

Angel also suffers from a heavy menstrual flow and has never consulted a doctor about it. When she complained of it as a teenager, her mother bought Dr. Weaver's Pink Pills, a generic medication commonly used for all menstrual ills in the Cape Flats communities. Her heavy flow is painful. Angel uses Grandpa, a popular generic painkiller. It seemed that Angel had developed a dependency on this popular painkiller. She has been using them three to four times per day for four years. She has thought of stopping but she says she is only able to do without them for a few days.

Angel has no family history of reproductive problems or infertility. She says that she has had two hospital-treated pelvic infections. She has never had gonorrhoea, vaginal warts or any other STD. She has never used contraceptives and has never had an abortion or a miscarriage. Angel became sexually active when she was 22 years old. She has had four sexual partners in total. She said that she realized that she might have something wrong with her when had not conceived after prolonged periods of unprotected sex. She said that neither she nor her partner had any idea what the problem could be, but they made no effort to seek treatment. They believed if conception was 'meant to happen, it would happen'. They were comfortable in their relationship but separated after seven years.

However, Angel may have become infected with a STD from her partner. She said that she was unaware of her partners' medical histories and so could not say if these men suffered from STDs or even if she might have contracted Pelvic Inflammatory Disease (PID) from them. She has never used any protection while engaging in any sexual activity. She thought that all STDs have visible symptom, and was surprised when I informed her otherwise. However, the cause of her infertility will remain unknown. Moore and Zimbizi (1996:446) support this speculation, stating "One third

of all cases of infertility in women result from pelvic infection due to STDs. Hormone imbalances account for another third. The cause of the remaining third remains unknown." Furthermore, Dr. Graham Barker (1980) states that infertility could be a result of various factors - stress in the workplace, family, financial circumstances or other personal problems.

Angel has not been able to conceive for eighteen years. In that time she has never consulted a doctor about her infertility. While she did not take the steps to access medical treatment, she was aware of facilities where treatment is offered. Ten years ago, Angel's ex-sister-in-law told her about the Infertility Clinic at Groote Schuur Hospital, but also said that Angel did not qualify because the facility only treats married women. Angel did not question her ex-sister-in-law's information, and just accepted that she would not be treated.

Angel has said that she is now able to seek treatment. However, one of the most important lessons that Angel's mother taught her was to pray about an issue and to consult her priest. Thus, before she seeks treatment she says she prepare herself spiritually, and then discuss the matter with her priest.

### **3.4. FINDING ANSWERS**

Veon's long road to diagnosis, illustrates the prolonged period required for them to realize they may be infertile. During her first marriage, Veon and her husband wanted to conceive in six months. When this time had elapsed, Veon decided to seek treatment. Her mother advised her to go to the Infertility Clinic at Groote Schuur Hospital. Veon did so, but was disappointed with the outcome. During her first visit,

the doctor at the clinic performed a Pap smear and told her that she would be informed of the results by mail. A year later she received a letter stating that she should schedule an appointment at the clinic because the test results showed abnormalities. The letter also requested that her husband accompany her for a sperm analysis. By that time Veon's marriage was troubled, and she decided not to return to the clinic. She had another Pap smear performed by a private doctor, and these results indicated that no abnormalities were present.

After her divorce, she entered a two-year relationship, then another that lasted four years. During the latter relationship, her partner took her to a gynaecologist who performed a Pap smear. Results again indicated no abnormalities. The gynaecologist gave her an injection but did not explain its purpose to her. The doctor also prescribed antibiotics to clear up 'an infection'. During this relationship Veon returned to the gynaecologist on numerous occasions but was not given a definite diagnosis. Veon believed that she was the cause of the couple's infertility as her partner had two children from a previous relationship.

During her second marriage, Veon sought medical treatment but once again was given no answers. Family and friends have told her that 'her tubes are blocked' but no doctor has given her such a diagnosis. She says that if they did she could start focusing on accessing treatment.

Veon's inability to locate a bio-medical explanation motivated her to conduct her own research. During one of our informal meetings she informed me that after conducting research on the Internet, she suspects she has endometriosis. I told her that I suffered from this condition and related my experience. She replied that she has had the same symptoms. She noted that, unlike her however, I was not trying to conceive a child.

Veon's personal trials due to infertility were exacerbated when she suffered a miscarriage. She was unable to afford a consultation with a private gynaecologist. Veon informed me that she had been unable to see a gynaecologist almost two months after she had suffered her miscarriage. I was so touched by her situation that I chose to cross the research boundaries and assist Veon in seeking treatment.

We decided it would be best to consult with my private gynaecologist, Dr. Howard. We had to wait for more a month before Dr. Howard could schedule an appointment with Veon. A week before the consultation I sent Dr. Howard an e-mail with a brief summary of Veon's history and the reason for the consultation.

At the consultation, Dr Howard informed Veon that he had received my e-mail and that he understood that he was to assess her. Though he already had some information, he still interviewed her. He enquired how long she had been trying to conceive, about her husband's fertility status and her own menstrual history, particularly whether she experienced irregular or painful menstruation. He then asked if she had any other medical conditions and if there was a history of any serious illness in her family. I was present throughout the consultation.

Veon said that her doctor prescribed an antibiotic while she was (unknowingly) pregnant. She wanted to know if the antibiotic was the cause of her miscarriage. Dr. Howard explained that antibiotics can cause the body to abort and so most doctors do not of prescribe them to pregnant women. However, safe antibiotics do exist. Veon could not remember the name of the antibiotic and so he could not comment on this issue. He explained that the foetus was aborted naturally.

Dr. Howard then asked Veon about her Pap smear results. Sensing her discomfort, I told Dr. Howard that Veon suspected that she has endometriosis. He then asked her again whether she experiences pain during menstruation. She became extremely uncomfortable when he asked her about her sex life.

Dr. Howard then performed an internal scan, which Veon had not experienced before. After the examination, Dr. Howard informed Veon that there was no need for a womb scrape, as her womb was empty. Her body had naturally expelled all the fragments left after the miscarriage. He showed her the ultra-sound monitor and it said that it appeared likely that she had PCOD. Dr. Howard went on to explain exactly what the condition is, and drew diagrams to illustrate his explanation. To be sure that his diagnosis was accurate, he required Veon to have blood tests, so that she could begin treatment as soon as possible. He told her that it was possible that she could finally conceive. The next day Veon had a blood test to measure her thyroid activity and glucose level. Afterwards she told me that she felt sad because she had wasted so many years searching for answers and now, had finally found them. Dr. Howard phoned Veon the next Monday to inform her that his suspicions were confirmed and she did indeed have Poli-Cystic Ovarian Disease (PCOD) (See Appendix 13 for the doctor's report). Veon's case illustrates the lengthy, sometimes frustrating journey that infertile women have to endure before they receive a diagnosis and assistance to conceive.

## **Conclusion:**

In this chapter, the bio-medical definition of infertility was presented, as well as definitions for two reproductive conditions that two of the participants suffer from. In order to gain a deeper understanding of the bio-medical causes of infertility, the fertility risk test was presented, which shows the biological causes of infertility as well as the factors that could lead to a diagnosis. Veon's story illustrated the bio-medical process of receiving a diagnosis of infertility. However, it was shown that the bio-medical definition of infertility does not take cognisance of the social and cultural aspects of infertility. Through the presentation of the participants' profiles, it was shown that these infertile women are aware that there is a bio-medical cause of their problem, but their understanding of their condition is rooted in the cultural explanations provided by friends and relations. The lack of basic understanding of the biology of reproduction is a consequence of the cultural taboo that surrounds openly discussing sexual or other related matters in the communities of the Cape Flats. This is exacerbated by the inadequate sexual education these women received, which focused only on socialisation of the cultural taboos on gender and sexuality as well as on appropriate gender behaviour.

These cultural prescriptions influence infertile women's treatment-seeking behaviour. They are unable to publicly discuss sexual or other related reproductive issues with members of their communities. They are also less likely to seek the possible biological causes of their infertility or to understand the complexity of their condition. Roxanne was an exception to this norm. She educated herself about these matters but it showed also that this information was gained outside the cultural realm of her community. The taboos placed on open discussion of women's sexuality or infertility

has influenced infertile women to seek solutions while attempting to escape stigmatisation.

In the following chapter, I will look at the medical and alternative treatment options that are available to infertile Coloured women on the Cape Flats. I will show whether or not these options are seen as viable, and what prevents infertile women from accessing certain treatments.



## **CHAPTER 4: OPTIONS FOR CONCEPTION**

In the previous chapter, the possible causes of infertility were dealt with and the routes that infertile women use to seek medical treatment were explored. The participants in this study cling to the hope that one day they will be mothers, mainly because they know that fertility-enhancing reproductive technologies exist. In South Africa alternative treatment for infertility is also available. This chapter will examine the medical and alternative treatment options that are available to infertile women. I will also show that these technologies do not necessarily benefit the women for whom they are supposedly created.

Roxanne is the only participant who has sought medical treatment for infertility. Apart from Desiree, who has been diagnosed with endometriosis, the rest of the participants have only recently begun this journey. In the South African context, infertile women have two routes to take in receiving treatment. The first is the medical route. Due to technological advancements, infertile women have access to new reproductive technologies that enable humans to overcome biological restrictions to reproduction. Infertile women view these as a saving grace in their struggle to conceive. However, these methods have deeper undercurrents. The saving grace is not always available to those who need it most. Some feminists have also argued that these technologies are just a continuation of the oppression of women at the hands of men (Oakley, 1993). In this chapter, I explore three medical options that are available to infertile women from the Cape Flats. These are in-vitro fertilisation, surrogate mothering and egg and sperm donation. There are other medical options available but these three are most commonly known.

The second route that infertile women from the Cape Flats can take is alternative treatment. Because of difficulties in accessing reproductive technologies, most often financial, infertile women have been opting for alternative treatment to assist conception. These range from using herbal remedies and consulting indigenous healers to the religious realm. Exploring the viability of alternative treatments also stems from the participants' perception that they are useful for treating certain ailments. In this chapter, I will examine whether this perception extends to the treatment of infertility.

In addition to documenting the treatment options available, I will explore how the participants view themselves in relation to these treatments, and whether the treatments are in fact useful. Firstly, I will present arguments for and against reproductive technologies and their viability for infertile women. Secondly I will present arguments on the validity and viability of using alternative treatments. This section will also explore whether or not the participants self-medicated, and the role that religious faith played in their quest for conception.

#### **4.1 REPRODUCTIVE TECHNOLOGIES**

After years of searching for answers, infertile women become desperate in their quest to be mothers. Lasker and Borg (1989:11) state "The search for parenthood by infertile women has been compared to a terminal cancer patient's quest for a cure." Dyer, Abrahams and Hoffman (2002:1661) support this view by stating that only a few infertile women will give up the struggle. They state that the majority persist for years, visiting numerous doctors and gathering advice. "Women actively looked for solutions to their problem and often showed great persistence in trying to access

help." These women are dependent on the skills of doctors, and defer treatment because they are ignorant of what treatment options are available and how to access them. Lasker and Borg (1989) point out that the reason infertile women are desperate is that not only have they failed to fulfil their own desires and vision for their lives, but they have also failed to conform to the powerful societal mandate of motherhood, albeit through no fault of their own. On the Cape Flats, infertile women are acutely aware of the social stigma attached to those who deviate from this norm. Thus it is not surprising that these women subject themselves to enormous risk and stress in accessing treatment, in an attempt to conform to the societal mandate.

I include this exploration of medical options mainly because infertile women on the Cape Flats believe that bio-medicine can cure their infertility. However, their access to bio-medical treatment is hampered, firstly by their lack of information on what treatment options are available and where they are found. Secondly, their limited knowledge of reproductive biology restricts their understanding of these treatments. Thirdly, the participants' socio-economic position often makes treatment unaffordable. Reproductive technologies are seen as 'easy' solutions for infertile women by biomedical professionals, but in reality they remain an unaffordable option because most working-class women are unable to pay for them.

#### **4.1.1 In-vitro fertilisation**

In-vitro fertilisation (IVF) is the most well-known treatment for infertility. Bellina and Wilson (1986) provide a basic summary of IVF. Treatment starts on the first day of a woman's menstrual cycle. Even if a woman's ovaries are fully functional, IVF specialists help the process along during days two to five of the IVF cycle by administering fertility drugs to stimulate the production of several eggs in a single

month. Daily ultra-sound testing monitors the development of the eggs inside the ovary. This is combined with daily blood tests to check that the oestrogen and Luteinising Hormone (LH) levels are increasing. IVF specialists monitor the growth of the eggs to determine the exact time that the eggs will be released. Precise extraction is very important because though the eggs need to be near maturation, when fully matured they spontaneously leave the ovary and cannot be retrieved. After five days, the fertility drugs are replaced by Human Chorionic Gonadotropin (HCG), to prepare the body for the release of the eggs. These extra hormones assist the ejection of the eggs from the ovary.

On day thirteen, a laparoscopy is performed to retrieve the eggs. Once removed, each egg is placed in an individual organ dish and kept warm, to mature while the sperm is being processed. Each egg is combined with washed sperm (this laboratory process breaks down certain enzymes to ensure fertilisation) in the organ dish and placed in an incubator. After twelve hours, each sample is inspected under a microscope to see if fertilisation has occurred. If it has, the sample (now an embryo) is returned to the incubator, where it is left to divide into between four and eight cells. The embryos are then surgically transferred to the uterus.

Roxanne is the only participant to have undergone IVF. She is also the only participant to have no faith in this procedure, as IVF did not result in conception for her. The other participants would consider IVF an option. Veon was the only participant apart from Roxanne who knew what the procedure entailed. After I explained the procedure to Desiree, Sarah and Angel, all three confirmed they would still consider it an option. This shows that while IVF is well-known, it is not always well understood.

Though all participants saw IVF as a possible alternative to natural conception, they all said they would be unable to afford it. Moore and Zimbezi (1996) support the argument that IVF is unaffordable for most women. They state that the average cost of IVF in South Africa in 1995 was between R7 500 and R12 000 per attempt. In 2006, the cost in the private health sector had risen to R25 000 per attempt. The average success rate is 25% (information provided by a qualified gynaecologist), but this depends on a variety of factors, such as age of the woman and the quantities of medication used. Because of financial constraints and other difficulties, not many people opt for this treatment. The following extract from an interview with Veon illustrates how infertile, working-class Cape Flats women in general feel about IVF: "If I was told that IVF was my only option, I'll go on my knees and pray like hell because I know that I could never afford it. Unless I win the Lotto, which I will never."

IVF is also the reproductive technology around which there is most debate. When this technique was developed, it was touted as giving infertile women the choice between childlessness and motherhood. But Bellina and Wilson (1986) state that IVF is one of the more controversial methods of enhancing fertility, because of its association with genetic manipulation. It conjures up images of clone-like generations of babies created and manipulated by mad scientists. It can certainly be argued that IVF is not necessarily beneficial to infertile women. While a lot of these arguments centre on women's marginalisation at the hands of mainly male scientists and medical practitioners, and the view that men control fertility-assisting reproductive technologies, it is also simply that most women cannot access IVF because of cost. This is most significant for this research because the ability to afford a specific treatment is a very important consideration for the participants. IVF is too complex

and too expensive to be a real option for infertile South African working class women.

#### **4.1.2 Egg donation and sperm donation**

The development of IVF made it possible for fertilisation to occur outside the female body. While this procedure gives couples hope, it assumes that the female's eggs and her male partner's sperm will be used. Donation, on the other hands, is premised on one partner being infertile. When a man is infertile, there is the option of sperm donation. Similarly, when a woman is infertile, there is the option of egg donation. While financial constraints were cited as the main reason why IVF is not a viable option, there is no singular main reason why the participants would not consider donation to be an option.

Roxanne would not consider sperm donation because it is not permitted by their religious beliefs - a child has to be born from a woman's husband to be considered the couple's legitimate offspring. When IVF is performed, a woman's husband's sperm must be used. Angel would not consider it because she would want to know who fathered her child. When Veon's husband thought that he had a low sperm count, he suggested they ask his brother for a sperm donation to be used in IVF. After he had a sperm analysis and found out that he had a normal sperm count, it was no longer an option. Desiree and Sarah would not consider sperm donation as an option, but could or would not provide a reason.

#### **4.1.3 Surrogate mothering**

Surrogate mothering dates back to Biblical times. Genesis 16 tells the story of Sarah, Abraham's wife, who was unable to bear him children. She told her husband that as

the Lord had made her infertile, Abraham should sleep with her maidservant Hagar, so they could build a family through her. He agreed with his wife and had sexual intercourse with Hagar, and she conceived and bore Abraham a son, who he named Ishmael.

When a man has been declared fertile and his partner infertile, surrogate mothering becomes viable. A couple then have the option of having another woman being (artificially) impregnated. Bellina and Wilson (1986) note that surrogate mothering is a very controversial issue in contemporary times, despite its Biblical sanction.

Religious leaders openly condemn the practice. The Roman Catholic Church views it as adultery and baby-selling. This relates to the most prominent objection from those who oppose the practice, which is the payment of money to the surrogate. There is no law that prohibits the payment of surrogates but also none that sanctions it. Bellina and Wilson (1986:346) state that there are two major questions that influence the practice of surrogate mothering: "1. is it lawful to pay a woman to bear a child for another person? 2. Who are the legal parents of children born out of the practice of surrogate motherhood?"

Given the importance placed on biological motherhood on the Cape Flats, the resistance of the participants to surrogate mothering as an option for infertile women is notable. None of the participants gave moral or legal objections to the idea. It can be seen that their refusal to go this route is based on emotional considerations and how it would affect their experience of motherhood.

Roxanne would see surrogate mothering as an option if she were unable to carry a pregnancy to full term. However, she knows that her husband would not support her in this. She was the only participant who would even consider it.

Desiree and Angel would not consider surrogate mothering because of the possibility of emotional complications. There is a risk that the surrogate would not want to part with the baby after bonding during pregnancy. Also, both felt the baby would not be 'their' baby because they did not give birth to it.

Veon also objected to the idea, for the same reason. Her sister offered to be her surrogate, but she felt that even if they used Veon's own eggs, the baby would be her sister's and her husband's, not hers. She also feared that it would cause emotional problems and deprive her of the 'whole' motherhood experience. Sarah was the only participant to reject surrogate mothering without providing an explanation.

It can be argued that these women are marginalised in terms of accessing fertility-assisting reproductive technologies. Firstly, they are constrained by their lack of financial resources, and by implication, by their class status. Lack of financial resources is characteristic of the working class. Even the two lower middle-class women are similarly constrained because infertility treatment is expensive. It is possible to access government-assisted infertility treatment but there is a range of other obstacles associated with this.

Secondly, the participants are constrained by the racial stereotyping in South African society. Coloured women are popularly seen in historical and academic literature created during the Apartheid era as being hyper-fertile and not needing assistance to reproduce. As a consequence of this stereotype, working-class Coloured women who are struggling with infertility also struggle to access treatment.



The following section is a continuation of the debate started in Chapter One, regarding who has access to reproductive technologies. Michelle Stansworth (1997) explores the impact that reproductive technologies have had on women's reproduction and whether they have positioned women to better control their own bodies.

Stansworth (1997:482) states that technologies designed to intervene in the process of human reproduction can be categorised in four groups. The first and most common group is concerned with fertility control, while the second is concerned with labour and childbirth. The third category deals with improving the health and genetic features of foetuses and newborns. The fourth and most controversial group involves technologies that promote pregnancies through medical interventions to bypass or overcome infertility. Due to these different and often conflicting interests in the application of reproductive technologies, women have opted to highlight the ambivalent effect of these technologies on their lives rather than leave them in the hands of the experts, who are most often responsible for their promotion as well.

Today, Western European and Northern American women have fewer pregnancies, fewer children against their wishes, are less likely to die during childbirth and are less likely to experience infant mortality compared to their foremothers. This is due to the intervention of human reproductive technologies.

However, the view that these technologies have enabled women to take complete control over motherhood and their lives is questionable. Medical and scientific advancements are often hailed as contributing to women's empowerment in the twentieth century. Certainly they have given women control over when and how and if they want children. But they have empowered the medical profession and the state, who owns the monopoly over reproductive technologies, to determine which women

can access these technologies and conditions in which they are granted access. Moreover, Stansworth (1997) argues that giving women a choice of fertility-enhancing or fertility-preventing reproductive technologies does not allow them full reproductive freedom. For many women, motherhood remains the only way of expressing 'self', while a minority voluntarily relinquish motherhood because of social and economic circumstances.

Stansworth (1997) also claims that the advancements in reproductive technologies provide men with the means to turn their illusions of reproductive power into reality. Through the ages, men's alienation from reproduction has fuelled the male desire to construct cultural patterns, control nature and create social institutions that will subjugate women and provide men with power and continuity. Integral to this view is the perception of infertile women held by some medical professionals. Infertile women are too easily "blinded by science", they are manipulated into full and total support of any technique which will produce those desired children, and the choices they make and even their motivations to choose are controlled by men. Furthermore, Stansworth (1997) argues that given this approach, motherhood that deviates from biological motherhood (that is, natural conception and birth) is represented as degrading the notion of motherhood. This is based on the assumption that all women have an affiliation with biological motherhood.

The most common reproductive technology is that which controls fertility and prevents conception. While it might be assumed that these technological advancements place reproductive choice squarely in the hands of women, the reality is quite different. Biomedical practice related to reproductive technologies is culturally influenced by masculinist values. Patricia Spallone (1989:2) supports this argument.

"Clearly, the technologies were not invented to serve women needs, but the various needs and desires of medical scientist, research scientist, to further technological progress and to aid population control aims, all of which required the use of women to those ends." However, these advancements have provided women with the ability to plan their reproduction.

The portrayal above of the perceptions that medical professionals have of infertile women (and by implication all women) is very important. While it states that infertile women are "blinded by science", I believe that women are aware of advancements that would allow them to attain those desired children.

Stansworth (1997) also deals with the issue of motherhood being natural, though in contemporary society most women use reproductive technologies to assist or control fertility. But in the context of the Cape Flats, the question of which women have access to these technologies is an important area of concern.

Anne Oakley argues from a feminist perspective that there is an assumption that reproductive technologies benefit women. While it has been argued the scientists who develop these technologies do so solely for philanthropic purposes, evidence suggests that this assumption is not quite correct. She bases her argument on the following three pieces of evidence. Firstly, world wide there is minimal interest in preventing and assisting infertile women. Oakley (1993:177) states this is possibly due to the fact that "medical technology have been instrumental" in causing infertility in the first place. The Pill and the IUD, which are contraceptives created in the 20<sup>th</sup> century, are seen as two of the biggest causes of infertility among women who have used contraceptives. Secondly, fertility treatment is for the most part gender-specific. Fertility-enhancing reproductive technologies such as IVF were created to benefit

women who are unable to conceive due to a reproductive problem. It is significant that this treatment is now being used in the treatment of male infertility. Regardless of which partner has the problem, it is always the women's body that is first subjected to treatment. For example, with male infertility, an abnormally low sperm count means that, if need be, a healthy, fertile woman's body will be subjected to hormonal stimulation and egg retrieval. Thirdly, IVF is not accessible to everyone who requests it, even if they can meet the high cost of the procedure. The outdated ideology that ideal parenthood occurs within the heterosexual nuclear family is used to control who has access to IVF (Oakley, 1993:178).

Anthony Giddens (1984: 14) "defines agency in its simplest, most eloquent sense, as people's ability to do things. He indicates that while many have equated agency with intention or motivation, agency or the capability to act can bring about both intended and unintended and often unknowable consequences that are recursive across time and space. Agency produces effect, 'makes a difference in pre-existing state of affairs', is therefore transformative and implies power." Oakley concludes that these women lack agency in accessing infertility treatment. They lack the ability to do things towards having the much-coveted child. Challenging this view, Denny (1996) argues that infertile women do have agency because they have power and the ability to seek solutions as far as they are able. She states that on the surface, it appears that infertile women have more power in accessing treatment than patients in any other sector.

I would say the reality is the problems these women face are on a deeper level than simply whether treatment is available. Infertile women do have the power to access treatment but they are constrained, often by cost. While motherhood is an important issue across all classes, the inability to access medical intervention illustrates the vast

gap between the haves and the have-nots in South African society. Access to treatment is also hampered by a lack of information on what treatments are available. In this study, for example, the participants had heard of IVF but they did not necessarily know what it entailed. This I recommend that infertile women in South Africa should be educated about the medical treatment options that are available. This should ideally occur in a safe, supportive environment where infertile women are comfortable to openly discuss their infertility. Supporting this view, Dyer, Abrahams and Hoffman (2002:1661) state, "Information is essential, as it is the basis for treatment as well as for prevention. Such information has to be delivered in a sensitive way." Dyer, Abrahams and Hoffman (2002:1661) state that in their study on the behaviour of women seeking treatment at the Infertility Clinic at Groote Schuur Hospital, it was observed that lack of information caused anxiety, which in itself could lead to women not accessing treatment. They argue that that it was an important finding that many women expressed a need for information. "It demonstrates that, particularly in the developing world, infertility treatment has to encompass information, health education and counselling."

#### **4.2 ALTERNATIVE TREATMENT**

The participants argued both for and against the use of alternative treatment for infertility. Some would (and have) self-medicated with herbal remedies and others would not. While our discussion of herbal remedies and non-prescriptive medicine obviously concerned infertility, I observed that some of the women also see these as a valid route of treatment generally. Similarly, there was support for the validity of

prayer and religious faith as infertility cures. However, the use of indigenous healers remains a contentious issue.

South African citizens are inhabitants of the global village. No longer are we forced to live the lives of previous generations, isolated by apartheid. We have access to the world through constant technological advancements. Traditional ways of living have been replaced by a Westernised lifestyle - we eat Western food, wear Western clothes, and have to all intents become part of a society which holds up Western ideals, morals and beliefs as the benchmark of civilisation. And many have turned our backs on the indigenous<sup>17</sup> cures used by our indigenous ancestors in favour of Western scientific medicine. But what happens when Western science fails? What happens when modern medicine cannot give infertile women the answers it claims to possess? For example, when IVF was developed, it claimed to give infertile women the choice between childlessness and motherhood. However, there is a considerable failure rate associated with this procedure.

Using the wisdom of those who came before us can sometimes give us answers unavailable elsewhere. In countries such as South Africa, infertile women have the option of relying solely on scientific medicine, or using a combination of scientific and indigenous or alternative treatments. Gijssels, Mgalla and Wambura (2005) support this argument, stating that infertile women use different sources. Some seek medicine at hospitals, others consult indigenous healers. Most combine the scientific with the indigenous to help them understand and treat their infertility. Dyer, Abrahams and Hoffman (2002) state that contemporary infertility services need to take cognisance of alternative sources, which include both medical and non-medical

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<sup>17</sup> The term indigenous is used rather than 'traditional' due to the latter's connotation to the primitive.

treatments. The following sections will explore the participants' use of alternative treatments.

#### **4.2.1. Herbal remedies**

Dyer, Abrahams and Hoffman (2002) cite an example of a woman who struggled for ten years to receive a diagnosis of the root cause of her infertility. She finally decided to consult an indigenous healer because she thought an evil spirit was hiding the cause. The return to indigenous medicine has also been brought about by an increasing awareness of the negative impact that manufactured products and synthetic medicines have on our bodies. Some of the participants use 'natural' medicine such as herbal remedies, recommended by friends and family members, to treat certain ailments.

Sarah was the only participant to show unfaltering belief in scientific medicine. She would not use herbal remedies because she believes that they are '*doekom*' (black magic used to inflict harm on others). She has not even tried any, as she says she does not like taking things that 'don't belong in your body'. The rest of the participants have all at least tried alternative medication before dismissing its validity. For example, Veon currently uses only medication prescribed by her doctor. But when she was younger, her maternal grandmother prescribed herbal remedy<sup>18</sup> to cure her irregular menstrual periods. Though scientific medicine failed to help her, she said that the herbal remedy ameliorated her condition. While she used it, she was not troubled by irregular menstrual periods.

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<sup>18</sup> The chemical content of the herbal remedy is unknown.

Angel's medicinal history proved very interesting. As mentioned in Chapter Three, she loves 'Grandpas' (a popular generic analgesic). She uses them to cure every imaginable ailment. When she is really sick, she will consult a doctor, but never completes a course of prescribed medication. She uses it until she feels better and then stops. Also, if she feels that it's taking too long to be effective, she will also use home-made remedies.

Before the birth of her son, Roxanne used homoeopathic drops for a few months to regulate her menstrual cycle, with no result. After the birth of her son, she tried reflexology to regulate her cycle. Though it did not serve its intended purpose, it cured the backache she suffered after the birth of her son, as well as her sinusitis.

Desiree truly believes in the effectiveness of herbal remedies. She has very little faith in scientific medicine and she was unable to afford the medicines most beneficial to her. After being diagnosed with endometriosis, she was prescribed medication, which she felt was harmful. She was prescribed another product with fewer side effects but could not afford it. She decided to stop taking all medically prescribed medication and started using homeopathic medication obtained from a registered homeopath, which relieved the symptoms of the endometriosis. She also refuses to use medically prescribed medication for any other ailment or problem.

The participants were also asked whether they had received advice from friends and family on what they could do to aid conception. Sarah was told not to urinate after sex, and to cleanse her vagina after sex. She was also told that her husband should put a cold cloth over his testicles before intercourse. When she repeated this advice to her husband, his response was *"Is dji dan mal, dan gan my eiertjies lyk soes rosyntjies."* (Are you crazy? My balls will look like raisins). She has never tried any of the



recommended methods. However, she claimed that if she was told that standing on her head would make her conceive, she would do it. Similarly, Roxanne has been given numerous suggestions. She cannot remember all the advice that she has been given over the years. She remembers that her husband's aunt once brought her an herbal mixture and said: "You drink this and you will fall pregnant." The same aunt also advised her to drink various other herbal remedies. She seldom used the advice that she was given. The fact that some of these women followed these spurious, unproven methods, are indicative of their desperation to conceive.

Not all women are subjected to this advice. Veon, Desiree and Angel have never received advice from friends and family on what to do to aid conception.

The participants' attempts to self-medicate their infertility are not unique to their condition. Women's self-medication for reproductive problems is documented in a study by Abrahams, Jewkes and Mvo (2002), who explored the self-medication and indigenous healing practices used by pregnant women in Cape Town, South Africa. They conducted a qualitative study with thirty-two pregnant women and seven indigenous healers. The sample included seventeen Xhosa-speaking and fifteen Afrikaans-speaking women. The study showed a difference in the ways that these women treated pregnancy, associated symptoms and preventative measures. "They responded in different ways to illness depending on their perceptions of the severity and nature of the problem but often spoke of attending after-hours clinics, a pharmacy, a private doctor or following self-healing practices, which included taking non-prescription medications, indigenous herbs, Cape Dutch remedies and a variety of other non-medicinal products." (Abrahams, Jewkes and Mvo, 2002:81). These findings

are supported by the observations in this study. The participants also used a range of products to cure their infertility.

#### **4.2.2 Indigenous Healers**

While the participants were willing to use herbal remedies, they were less keen on indigenous healers such as the Xhosa Nyangas, who are commonly associated with herbal remedies. All the participants said they would never seek treatment from a Black indigenous healer, firstly because such 'treatment' is considered a money-making scheme. Secondly, it is 'black magic'. And lastly, it is their perception that indigenous healers are charlatans. However, Veon had considered it in the past. She was desperate, and the advertisement she saw said that the indigenous healer could cure infertility. She thought it was possible that the healer could help her. At the time, she was divorced, in a new relationship and anxious to fall pregnant. "I was desperate and I use to think, can't I just go see what it's about and then I thought to myself about a verse in the Bible. I can't remember which verse but it says trust the Lord with all your heart and lean unto your own understanding. And I just thought to myself, no, it's wrong because if the Lord wanted to give me a baby with this guy, he would. So maybe if I do get married one day to the right person, I will experience all of those things. And I never thought about it again."

At present she would not consider seeking treatment from an indigenous healer as she now sees them as 'witchdoctors' and thinks that they use *doekom*. (Black magic)

Sarah was the most outspoken about rejecting indigenous healers. She believes that they are witchdoctors who use *doekom*. She says they claim to be prophets but they are not. She thinks that they exploit people's desperation, and that if one chooses to

consult a indigenous healer, one will enrich him because one return l constantly run to him if the remedies are not effective. She believes that all herbal remedies prescribed by anyone other than a medical professional are evil. Despite the fact that consultations in the bio-medical services work in the same way, she did not consider these to be exploitative.

Supporting the views of the participants, Stendahl and Mohlomi (2005) wrote an investigative article on indigenous healers. This popular media source was included because it illustrates the perceptions that exist about them. Stendahl consulted with Professor N, complaining of imaginary symptoms including feeling sad and crying a lot. The indigenous healer rolled the bones and informed her that she was cursed – her luck had left her. He prescribed 'medicine' to cure her of her curse. While she was in his presence, the way in which he addressed her made her actually believe what he was saying. When he said "I could make you become the woman you want to be" (Stendahl and Mohlomi, 2006:26), it struck a chord with her. However, she came face to face with his exploitative nature when she was told that the cost of her treatment amounted to R828.00. The next day Mohlomi consulted the same indigenous healer with imaginary stomach pains. Mohlomi, who had more knowledge of indigenous medicine, soon realised that the healer was a charlatan and was exploiting people who believe in the power of indigenous medicine.

While the participants did not have faith in indigenous healers, Dyer, Abrahams and Hoffman (2002) report that in their study on reproductive knowledge and treatment-seeking behaviour among involuntarily childless women it was found that several women had consulted indigenous healers for answers to their infertility. Twenty of their quantitative sample of 120 women, mostly black South Africans, had consulted

an indigenous healer about their childlessness. Through their qualitative sample of thirty women, they were able to gain insight into indigenous health care in South Africa. "These women had actually received some 'herbs' or 'medicine' to drink to be 'cleaned'. Others were told that a jealous woman (a previous girlfriend or mother-in-law) had bewitched them. As one informant explained: 'We went to the witchdoctor and he explained that another woman had bewitched me. If I sleep with him (husband)... everything comes out.' Another woman was informed that she was possessed by ancestors and that she would have to become an indigenous healer." (Dyer, Abrahams and Hoffman, 2002:1660).

Their findings are supported by other studies. Sundby's (1997) study of infertility in Gambia focused on indigenous and modern health care. In the Gambian context women only resort to modern health care when indigenous health care has failed. In Mozambique, infertile women visited indigenous healers more often than medical doctors. They were willing to spend more money on indigenous care than modern health care.

#### **4.2.3 Religious Faith**

Veon's story illustrates the unwavering faith that some infertile women have in prayer as an infertility cure: "My mom said I should just hang in there and to constantly pray 'cause God knows what my desires are and he will tend to them when it's the right time, but I can see that is sad for my part and like I believe any mother or parent for that matter would do anything for their child and if she could, she would help me in an instant. But my faith is also there 'cause God is my father and he will give it to me in due time. 'Patience, my child, patience.'"

Veon and Roxanne are the only two participants who believe unfalteringly in the power of prayer to cure their infertility. Roxanne believes that when the time is right and when God wants her to, she will have another child. She strongly believes that it is in God's hands because people told her that she would never have children, and through prayer she proved them wrong. She asked people to pray for her to conceive when she wanted her first child, and is asking them to do so again now. She especially asks family members who go to Mecca for the Islamic pilgrimage. She believes that there is power in these prayers because she could not imagine conceiving naturally, and yet she did. She has hope that it will happen again because although she is not receiving any infertility treatment, she still does pregnancy tests regularly, and even more often when a family member is on pilgrimage to Mecca.

Veon strongly believes that if she prays enough, God will give her a baby. She said that in the Bible says that you should seek out prayer, and she did. When she asked her pastor to pray for her, he asked if she had been to a doctor. She was very surprised, and replied, "But what does that have to do with prayer because the thing is this, if you pray for something and you believe, then why are you asking me about the doctor?" He pointed out that it is possible that she has a medical problem (perhaps 'blocked tubes'), and that it is not a sin to seek medical treatment. Since then Veon believes that one can pray, but one should also help oneself by seeking medical treatment. She says that is another way in which God assists one, because He gives the doctors the knowledge to help. On another occasion, Veon's mother advised her to seek prayer from a pastor at the Universal Church. He prayed for her, and soon after, she conceived.

Angel, Desiree and Sarah do not believe that prayer will help them conceive. Desiree is a very spiritual person and actively involved in the church she attends. However, she would never ask someone to pray for her. She believes that prayer can cure, but "for me I believe that not everything that happens to us is meant to be cured, you know. Cause for me, I see it in the sense that, that might be my cross that I need to carry and I can thank and praise God despite of how I'm suffering, you know, or would I only serve him because he has cured me."

Similarly, Angel has not asked anyone to pray for her to conceive. She argues that ones' situation is the result of God's will. Angel does not believe in the power of prayer. Sarah also believes that it is pointless to ask someone else to pray for her because she could pray for herself if she wanted to. She thinks that people who claim that God gave them the gift of healing others through prayer are phonies.

These stories illustrate that at least amongst these informants on the Cape Flats, there is a belief that prayer and unfaltering faith can cure any condition, including infertility. They also indicate that it is an individual choice to accept or reject this belief. In this context infertility is not only socially and culturally defined (see Chapters Three and Five), but that infertile women believe that there is also a religious dimension to its cause (see Chapter Six).

## **Conclusion**

In this chapter I dealt with the medical and alternative treatment options that are available to infertile women on the Cape Flats. It was shown that the informants are lacking knowledge about the complex biological processes involved in human

reproduction. This is to be expected as these infertile women are ordinary women and not trained biomedical professionals. Also they have a limited knowledge about the variable rates of success of reproductive technologies and treatments namely IVF, surrogate mothering, egg and sperm donation. Their understanding of reproductive technologies is also influenced and restricted by their limited knowledge of reproductive biology. However in the context of the Cape Flats, surrogate mothering poses profound ethical questions in the social realm of these informants. I have shown that these women were constrained in accessing medical treatment through lack of finances, lack of knowledge about treatment options, and by the cultural prescription that valorises biological motherhood. Motherhood by other means has social stigma attached to it. The participants themselves believe that only children born from their own bodies can be seen as their own children. This illustrates the power of biological motherhood.

In terms of alternative treatment options, infertile women have easier access to these treatments. However, the notion of 'appropriate' treatment influences what is permissible in the communities of the Cape Flats. For example, the Coloured women in this study permit themselves to use herbal remedies but not to seek treatment from a 'black magic'-using indigenous healer.

In Chapter Five I will explore infertile women's access to medical resources for infertility treatment on the Cape Flats, through examining the public and private health care sectors in South Africa. I will also investigate the procedures and constraints involved in receiving treatment from both sectors.

## **CHAPTER 5: 'NO MONEY, NO BABY': INFERTILE WOMEN'S ACCESS TO RESOURCES FOR INFERTILITY TREATMENT ON THE CAPE FLATS**

The South African public health system does provide some services to address infertility. However, as I will argue in this chapter, individual women (and men's) access to these services is not easy. The South African health system consists of a public health sector and a private health sector. The public health care system is overburdened and to access medical treatment for infertility as I will show, is difficult. The private health care system, on the other hand, is able to provide more accessible treatment for infertile women if they are able to pay first. However, the majority of South African women, and specifically women from the working-class communities of the Cape Flats, are unable to access private health care due to the high costs involved, particularly for infertility treatments, because it is exorbitantly expensive.

In this chapter I will examine how the respondents negotiated the private and public health services in their attempts to conceive. Most of the infertile women in this study rely on the public health sector to provide treatment for their condition. However, women's reproductive health care competes for state resources alongside other more pressing issues such as the HIV/Aids pandemic, and the tuberculosis epidemic in the Western Cape. In this scenario infertility cannot be prioritised by the state. The number of available specialised health care clinics in the public sector (and, by inference, the amount of funding) for infertility treatment is insufficient. On the other hand, the prevalence of contraceptive services in the public sector perpetuates the stereotypical image that all women are fertile and do not need assistance with reproduction. There has been an attempt to address the need for treatment through the Infertility Clinic at Groote Schuur Hospital, but as I will show, this facility cannot



serve all who need it. For the few who are treated, there is still the possibility that treatment will not result in conception. This is of importance because it contradicts the perception that with contemporary technological developments, all infertile women can be helped to conceive that much-coveted child.

First I will present Roxanne's story of her experiences at the Infertility Clinic. This narrative will be followed by an investigation into whether infertile women are able to access both the private health sector and the public health sector and if not, what factors constrain their access to treatment. The section on the public health sector will also focus on the participants' perception that health professionals' morals and beliefs influence the treatment that patients receive. This is followed by an exploration of what happens when treatment has failed and there is no hope. It details the participants' feelings about not being able to become biological mothers and about being mothers to adopted children.

## **5.1 ROXANNE'S STORY**

Roxanne's story, obtained from the research journal she kept for this project, illustrates the process that most infertile women go through as they seek medical attention in the public and private health sectors in South Africa.

"When I was eighteen years old, I didn't get a period for three months. I went to see our local GP at the time and he was convinced that I was pregnant. After assuring him that I was not sexually active and I was not pregnant, he referred me to a gynaecologist. She examined me and sent me for an ultra-sound. The ultra-sound revealed some 'little problem with my ovaries'. I didn't take much note at the time

because she said that it was not a matter of concern and the only form of medication/treatment she could offer me at the time was a contraceptive because I was a unmarried Muslim girl. She said she'd give me two weeks before she put me on the Pill but I should call her if my period started before that. A few days later I got my periods and that was the end of that episode. I was back to square one.

"Three years later, on January 10<sup>th</sup> 1993, I was married. The week after I was married, my periods began. I remember because it was a particularly heavy flow. After that my problems started. My periods were 'nonexistent'.

"A few months later I became a patient at Groote Schuur Hospital (GSH). They did an ultra-sound and discovered that I have polycystic ovaries. Something quite common, they assured me, that it only really causes problems when one wants a baby. They tried to regulate my periods by putting me on the Pill for a few months. When I stopped the Pill my periods stopped again. They tried a second time with the same result.

"I went for various other tests but they didn't find any problems. Because I really wanted a baby, they decided to put me on fertility treatment. By this time almost two years had passed and we were already in 1995. After two different (different because they have different types of infertility treatment) and unsuccessful cycles, they did further tests.

"One of the tests they conducted was a glucose tolerance test (diabetic test). According to research conducted at the time, people who tended towards being diabetic could conceive if they were on 'sugar/diabetic' tablets. Hence, I started taking

Metformin. I had to take it for three months before they started infertility treatment again.

"I fell pregnant for the first time on my second infertility cycle. We were now in February 1996. However, for some reasons, things didn't go as planned. 'Our' joy of having fallen pregnant after three years of marriage was short-lived. After three scans they couldn't find the foetal heartbeat. I was now 11 weeks pregnant. The doctor who performed the scan told me that I probably imagined that I was pregnant. This upset me totally. I went back to the Infertility Clinic and told them what had happened. They assured me that the test was definitely positive and arranged for another the following week. I couldn't wait so long, so I went to another doctor for a scan. He explained to me that I was pregnant but that I had unfortunately miscarried. Shortly afterwards, we tried again. I fell pregnant for the second time. We anxiously awaited the first scan. All was well – the baby had a healthy heartbeat. As I entered the second trimester of my pregnancy, GSH discharged me from their care because they only see patients who have difficult pregnancies or other illnesses e.g. high blood pressure.

"I made an appointment to see a private gynaecologist immediately because I didn't want any complication. Two days later, on a Wednesday, I went to see him. Since early that morning I had been experiencing what I now know was contractions. They were very faint and I told him about it. After examining me, he said that all was well and what I was feeling was probably the womb that was stretching to accommodate the growing baby. I went to visit my mom after that. That afternoon I felt a heavy sensation between my legs (almost as though something wanted to come down). I phoned the doctor in a state of panic and he called me in for a scan. The scan revealed

that my placenta was lying low. He said that I should go home and rest and prescribed some tablets to stop any contraction that I might have.

"I went home to rest. Towards the evening my contractions started again. I phoned the doctor and he instructed me to meet him at Kingsbury hospital. He 'hooked' me up to a drip to stop the contractions. The contractions stopped but he decided to hospitalise me for a few days for observation. On the Friday my waters broke. This was BAD news. He suggested a transfer back to GSH, as it seemed inevitable that I was going to lose the baby anyway. I was transported back to GSH by ambulance on the Saturday morning. At GSH they explained to me that I had developed a heavy infection and because my waters had broken the baby would not survive because its lungs were underdeveloped. Their primary concern was my health. I was sedated the entire day with morphine. After discussing the situation with us, it was decided that I'd be given a drip to go into active labour so that the baby could be 'aborted'.

"On Saturday night at 11 pm, my drip started. A mere three hours later my first son was stillborn. He was named Abdullah and buried on the Sunday morning, not even a week after my being discharged from GSH and having been pronounced fit and healthy.

"After a short recovery, we decided to try again. My first cycle was unsuccessful. I opted to do an in-vitro fertilisation (IVF) cycle because I was convinced that I would be pregnant and I was getting impatient. My cycle started. My follicles (eggs) grew well. When they were ready, I was admitted to theatre to remove them. They were fertilised and two days later they were implanted in my womb. Of the three they implanted only one survived. Once again, I was pregnant (for the third time in the space of one and a half years).

"After much discussion it was decided that UNDER NO CIRCUMSTANCES was I to be discharged from GSH. All was well, my sugar levels were fine and every precaution was taken to care for me and the baby. They even decided (at 4 months) to do a scan to see if the mouth of the womb was opening up. The scan was satisfactory but just to be on the safe side, they decided to do a scan two weeks later. However, that was not meant to be. A mere four days after my scan, my womb started to open up, I was bleeding and my contractions started. The doctor I saw upon arrival at GSH was very brusque. To him I seemed to be just another unfortunate patient. He wanted the labour to proceed and the baby to be born. I was only four and half months pregnant at the time.

"I requested to see the Head of Department, Professor Zephne Van der Spuy. She was my doctor at the time. She was very compassionate, and concerned about me because she knew my case history. In fact, no matter which doctor I had, she always took an interest in me as a patient. She promised me that she would do everything in her power to stop my labour. She put me on a drip and ordered bed rest for me. I had to lie with my feet elevated in bed. This happened on a Tuesday morning. Soon my contractions stopped. By the Saturday, my condition became worse. I started bleeding dark blood (from the womb). I waited for (the) professor patiently because she was in meetings the whole day and the other doctors did not want to make any decisions regarding me. One particular doctor was very sympathetic towards me and was prepared to operate and stitch my womb closed but the ultimate decision was the professor's. Professor Van der Spuy arrived late afternoon and she explained to me that if they do the op and my waters broke in the process, I could lose my womb in the process. She said she would rather I lost the baby and try for another one than me risk losing my womb.

"Thus, once again, I faced another labour resulting in a stillborn baby. My drip was removed and I started going into labour. Labour was slow. I only gave birth that following afternoon at lunch time to my second son, named Abbas.

"I decided to take a break from infertility (treatment) for a year to recover and pull my life together. This time fate smiled at me. Two months after I lost my baby, I was pregnant and no medication. I made an appointment to see Professor Van der Spuy. This was also my postnatal examination after my baby. After asking me how I was and promising me that when I fell pregnant again, they would pull out all the stops, I announced that I was pregnant. She couldn't believe it. She put me under the wing of a very caring doctor because she herself spends too much time travelling and doing research. For the first three months I went for weekly check-ups. After three months my womb was stitched up to prevent it from opening prematurely. Anyway, at seven months, I started to bleed. On arrival at GSH, they injected me with steroids to improve the baby's lungs. This on 1 November 1998. My son, Azhur Allie, was born on 4 November 1998 at 10:10 pm.

"I've never been pregnant since then but I'd still like to have another baby. Bianca, I shed a tear here and there as I'm sure you have too. My son changed our lives completely. After six years of having no children, he really made his presence felt and still does. However, the sacrifices mothers make are worth the joys of seeing your child grow up. It's not always easy but in life, nothing ever is."

Roxanne's story is by no means an unusual one for infertile women. Unlike other women, however, she was fortunate. Under the watchful eye of the Director of the Infertility Clinic, she was able to conceive and bear a baby.

For many women, access to both material resources and a sympathetic clinician spells the difference between a successful conception and life-long infertility.

## **5.2 ACCESSING MEDICAL TREATMENT**

Once infertile women have come to terms with their infertility, they face another hurdle in their quest to conceive. They have to obtain the financial resources to pay for infertility treatments. Infertile women have to juggle the costs for treatment with other day-to-day costs. This proved to be difficult for the majority of the participants in my study, who come from working-class to lower-middle-class homes on the Cape Flats. For them, the only option is to seek treatment in the public health sector.

### **5.2.1 The public health sector**

The South African public health sector is divided into three tiers; primary, secondary and tertiary. Primary health care consists of basic health services most often provided at local health clinics, such as the Manenberg clinic. The second tier includes facilities such as day hospitals. The third tier includes major hospitals such as Groote Schuur, where more specialised medical care, such as surgery, is available. At the third tier, people are able to also access an even higher level of treatment through facilities which provide specialised care, for example the Infertility Clinic at Groote Schuur Hospital.

In the Western Cape, the health services provide medical treatment to 4 757 000<sup>19</sup> people. Of these, 2 893 247 reside in the Cape Town metropolis. According to data there are 54 hospitals in the Western Cape, of which 17 are located in the Cape Town municipality. There were 258 primary health care clinics in the Western Cape, of

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<sup>19</sup> The number recorded in 2001.

which 108 are located in the Cape Town municipality. 2003 data, there were 31 214 registered doctors in South Africa, of which 1069 provided treatment in the Western Cape. In this province, the doctor to patient ratio is 1: 4 435. In 2003, there were 184 459 registered nurses in South Africa, of which 3 812 provided treatment in the Western Cape. The nurse to patient ratio in this province is 1:1 244. These ratios are good compared to those of other South African provinces (South African Institute of Race Relations Survey, 2004/2005).

This statistical information shows that the South African health sector is overburdened and struggles to provide adequate medical treatment for its population. This situation applies to the health services in the Western Cape as well. Even though the public health sector is said to be the best in South Africa, the need for infertility treatment puts an additional strain on a system struggling to provide even basic services. In this context, infertility treatment will not be prioritised.

To contextualize this information, statistics on the number of health professionals were sourced from the World Health Organization (2007).

Country	Year	Physicians		Nurses		Community health workers		Health management and support workers	
		Number	Density per 1000 population	Number	Density per 1000 population	Number	Density per 1000 population	Number	Density per 1000 population
<b>South Africa</b>	2004	34 829	0.77	184 459	4.08	14 306	0.32	22 859	0.51

These statistics were compared to three other African, three developing and three developed countries in 2004 (Appendix 20). They show that South Africa provides better health care than the other African countries and the developing countries, but not the developed countries.



There is a general perception that the South African public health sector provides inadequate services. People complain about inadequate treatment, rude and insensitive staff, and delays in accessing treatment. But the socio-economic position of the majority of South African citizens means that most have to use the public health sector. Rispel and Goosen (1996) state that most South Africans depend on the public sector for health care, because private health care is unaffordable. This sector is not necessarily more accessible than the private health sector. Rispel and Goosen (1996) indicate that the South African National Health Care Services are plagued by problems both inherited from the past and caused by the recent (and ongoing) restructuring of services. Currently, it seems the South African health services are often unable to meet the health needs of its population and women's health needs, regarding infertility is marginalised.

In this scenario, the participants reported that the first problem they encounter as they seek medical advice is that it is time-consuming. Angel states that if one wants to make use of this sector, it's best to take a day off from work. She said that recently she waited for four hours to have a Pap smear performed at her local health clinic. The clinic she attended is understaffed, and there is only one nurse to provide both reproductive and paediatric care. Desiree and Veon shared Angel's sentiments.

Public perceptions do not help matters. The participants tended to perceive the problems of service delivery in the overburdened health care system as entirely the fault of the professional staff. Sarah said that nursing staff are insensitive to the needs of their patients. Desiree said that health care professionals were insensitive and did not respect patient-nurse confidentiality. She argues that nursing staff do not have the interpersonal skills to deal adequately with patients. Similarly, Veon expressed her

dissatisfaction with the treatment provided by nursing staff. She said they lacked compassion and that their treatment is not "even fit for animals".

Sarah said that when seeking treatment in the public sector, you have to make do with what you get; one has to make do with available services, even if it's not the best. Sarah's opinion reaffirms the women's perception that private medical care is better even though this may not be true. Desiree, however felt that individual's need to educate themselves about their health. She said that people complained about inadequate services and handing over their power to the doctors. She said that these complaints about treatment only burdened healthcare professionals further.

Like Desiree, Roxanne did not complain about the public health sector. In general, she thinks that their services are good. Her experience and opinion of this sector is not only restricted to the Infertility Clinic at Groote Schuur Hospital. She said that she makes use of this sector on a regular basis and has always received adequate treatment.

I put these complaints to Sister October, the Director at Manenberg clinic, and inquired about the perceptions that healthcare professionals lacked sensitivity and compassion. She replied that the unprofessional treatment was a consequence of the nurses being overworked. She said that in the process these professionals tend to lose their sensitivity to patients. However she argues that the workers heavy workload was not an adequate excuse for unprofessional behaviour. She said that the nurses chose to enter the profession. She conceded that conditions of service have changed drastically. Workload has increased, and staff numbers have decreased. Accordingly, management has advised staff working in the public sector to use their time 'smarter'. However, in an overburdened health sector, time is stretched to the limit as it is.

## **Access to financial and medical resources**

While the participants are separated by class differences, they share the common struggle for access to effective fertility treatment. Accessing any medical resources in South Africa is a costly endeavour. This cost is higher in the private sector which is favoured over the public sector. Most of the women I interviewed thought that private medical treatment was better, because one pays for the service. They did not think that public healthcare services could be improved. These women say that access to satisfactory medical treatment through the public sector is difficult. Yet access to infertility treatment in the private sector is unaffordable. This leaves these women with few options. Aquifa's story illustrates the impact of one participant's financial position on her access to medical resources.

### **Aquifa:**

Four days after Aquifa's birth, her parents divorced. Her father provided no financial support. The family survived on the child maintenance grant her mother received from the state. Aquifa's upbringing was filled with hardship. The family struggled financially, unable to survive on the grant her mother received. In grade ten Aquifa decided to leave school to find employment, as there was no opportunity to study further. No one in the household was employed at that time. Since leaving school, she held low paid jobs. Two years ago, Aquifa was married, and the couple live in her maternal home. Aquifa's options for infertility treatment are restricted. Her job does not provide medical aid, and her access to multiple treatments even in the public sector is unlikely. The couple's joint income prevents them from even being able to afford complete treatment at a state hospital. She has not consulted a doctor or a gynaecologist about her infertility. On one occasion she scheduled an appointment

with a general practitioner, but eventually did not see him. She knows that she needs treatment, but clings to the belief that she will conceive 'naturally'. Her biggest obstacle is being able to afford medical treatment for her reproductive health problems. In a household where the cost of day-to-day survival takes priority, it is very unlikely that she will ever be able to afford medical treatment for her infertility.

Sister October of Manenberg Clinic agrees that the biggest obstacle in accessing infertility treatment is financial cost. This is due to the inadequate budget allocations for the public health sector. She said that the state prioritised funds for the prevention of teenage pregnancies. The concerns about the rising population growth rate means that prevention of unwanted pregnancies takes precedence over the allocation of funds for the treatment of infertility. She said however, that the state should make infertility treatments more affordable. Dr Silke Dyer from the Infertility Clinic disagreed. She argues that there are social and cultural issues associated with conception on the Cape Flats; that academics and health professionals barely understand. These issues may influence who has access to treatment and why this is so.

### **Infertility treatment in the public health sector**

Moore and Zimbizi (1996) concur that infertile women can seek infertility treatment in the private sector, but do not do so because of the high cost. These women have no alternative but to seek treatment in the public health sector.

Women initiate the treatment process, when they suspect that either they or their partners are infertile. It is significant that women initiate treatment rather than men. The first step in accessing treatment in the public sector is through a consultation at the local health clinic. They then obtain a referral letter from the healthcare

professional there, to consult with a reproductive health specialist at a specialist healthcare centre such as the Infertility Clinic at Groote Schuur Hospital. The healthcare professionals at the clinic define a woman as potentially infertile if she has been trying to conceive for a year. If she already has a child, she is considered infertile if she has tried to conceive unsuccessfully for two years. These time frames are used as the main determining indicator of infertility. The healthcare professionals however, rarely take account of the stress and suffering these women experience in their quest to conceive.

The women's reproductive history is then examined more closely. First they ask if the woman has used any contraceptives. If she has, they will examine the method used. If a woman has never used contraceptives, never conceived and her husband has had children from a previous relationship, she is classified as infertile and referred to the Infertility Clinic at Groote Schuur Hospital. In cases where an individual woman is childless and neither she nor her husband has been for prior tests, a referral letter is also given.

Infertile women mistakenly assume that they will be 'treated for infertility' immediately at their local clinic. These primary health care clinics cannot provide the specialised treatment required. Dyer, Abrahams and Hoffman (2002:1661) like Sister October concur that the state's public health system, and more specifically, the primary health care system, is ineffective in the care of infertile women. In the study they conducted at the Groote Schuur Infertility Clinic, they found that some women were provided with erroneous information at the primary health clinic. In Dyer et al's study several women were told that 'their wombs are dirty' and received tablets for

'cleaning'. Others were informed that there was nothing 'wrong' with them or that pregnancy would occur naturally.

Once a woman has been referred to the Infertility Clinic, she is given an appointment for a consultation. Sister October estimated that R2500 must be paid for the initial consultation. The patient is informed of these costs and then must decide if she can afford the initial consultation or not. The cost for this consultation is beyond the reach of many Cape Flats women. The woman also receives pre-treatment counselling at the Infertility Clinic to assess if they are able to assist her. Sister October was unsure what these assessment criteria were.

For many women the Infertility Clinic at Groote Schuur Hospital is their only hope.

Dyer, Abrahams and Hoffman (2002:1657) say that "Groote Schuur Hospital's Infertility Clinic is one of the few tertiary public health institutions in South Africa delivering a reproductive medicine service focusing on the needs of the indigent community. The reproductive medicine service offers modern infertility treatment ranging from endoscopic reconstructive tubal surgery to assisted reproductive techniques. Each year, nearly one thousand couples are referred to the facility, most commonly from the local primary care services or from general practitioners.

Although the large number of referrals reflects the need for treatment, the effectiveness is compromised by a higher patient default rate (approximately 65%)"

However, not all women who seek treatment at the Infertility Clinic will be able to access treatment. Roxanne said that the Infertility Clinic is not equipped to deal with the large number of patients referred. She argued that women who are accepted receive the best treatment humanly possible. To make this happen, the Clinic has to be selective in their admission policy.

According to Dr Silke Dyer, all women have access to treatment at their facility.

Constitutionally, all women are eligible for treatment, regardless of marital status or sexual orientation. There are some criteria with which they must comply:

- They must be in a stable relationship.
- The couple should have been trying to conceive for at least a year.
- Women younger than 42 years of age (Older women are considered to be at the end of their reproductive cycle and will not be treated unless they agree to egg donation.
- Only women suffering from primary or secondary infertility will be treated. A woman wanting a third or more children in an existing union will not be treated. If she has children from a previous union, she will be eligible, if she can prove that the children are well cared for.

However, the women interviewed say that there seems to be a difference between official policy and implementation. Some thought that individual healthcare professionals' attitudes at the Infertility Clinic often determined who gains access to treatment. Roxanne, who had been a patient at this facility, said that the nurses at the Infertility Clinic interview prospective patients before they are admitted for treatment. One particular nurse told Roxanne that she asks patients if they have had an abortion. It seems that women who have had one, have less chance of being treated. It is possible that nurses who are against abortions may bring their morality to bear upon selection of prospective patients. Sundby and Jacobus (2005:267) agree that health care workers wield individual power over their patients, especially those from disadvantaged communities. They state, "Generally speaking, there is hierarchical culture around most medical services in developing countries. Within this culture, the

health care worker has a monopoly of power and knowledge; the opinion of the client is not valued." This power combined with the marginal status of the infertile women who seek treatment, means that these women are unlikely to demand better services. However, it is important to mention that in South Africa infertility treatment is a specialised service. Thus, access to treatment is determined mainly by patients' ability to meet the high cost of treatment.

Dr Dyer stated that every existing treatment is used at the Clinic and these come at a price. Consequently treatment is not necessarily free. A minimum fee is payable, even though the government subsidises certain procedures. For example, patients pay R12000 for IVF, in comparison to R25000 in the private sector. This is by no means a small sum, despite the reduction. Roxanne, who was the only participant to undergo successful treatment at the Infertility Clinic, said that even when she started treatment thirteen years ago, costs were high. Most of her money was spent on medication. Prescribed fertility drugs prescribed cost R1000.00 at a time.

The Infertility Clinic is also a research facility, and is able to use advanced reproductive technologies. So, if treatment is unsuccessful at the Infertility Clinic, nothing else can be done, and the woman has to accept that she will never be able to conceive.

A woman's ability to meet the cost of treatment at the Infertility Clinic is often only the first of many constraints. In the following section I will examine other constraints identified by the participants. I will first examine two participants' experiences at the Infertility Clinic and then show how the rest of the participants view their access to treatment in the public sector.



Eight years ago, Roxanne and Veon were both patients at the Infertility Clinic. Their experiences will illustrate how treatment can differ in quality in the same facility. Their different experiences illustrate that the health care sector can be perceived as delivering biased treatment. The attitudes and beliefs held by health care professionals determined how one woman received excellent treatment (resulting in the birth of her son) while another was left feeling angry and disappointed.

Roxanne was 21 when she married in 1993. After a year of unsuccessful conception attempts, she sought treatment at the Infertility Clinic. She doesn't think that this facility is accessible to all women because it's very difficult to gain admission. She believes that she was 'lucky' to be accepted. Her entry was facilitated by a referral letter from a private gynaecologist, who advised her to take this route because private treatment was unaffordable. She believes that a lot of infertile women do not want to use the public health sector, because they perceive the private health sector to be better. She feels that the public sector is unfairly stigmatised. When she experienced a second miscarriage, her family and friends blamed it on the inadequate treatment she received in the public sector. Roxanne's cousin also struggled to conceive, but refused to use the public health sector. She subsequently bore two children. Now the cost of using the private health sector has put her in severe debt. The perceptions that prevail about private medical care are so powerful that women will choose it over the public health sector, even though it is extremely expensive.

Roxanne thinks that the treatment she received at the Infertility Clinic was excellent. She said that she was never made to feel that she was just 'another patient'. The doctors tried their best for their patients and used the most advanced treatments.

Roxanne's opinion of the Infertility Clinic is clearly influenced by the treatment she received from the Head of the Infertility Clinic, Dr. van der Spuy. She is aware that there were women whom she said were treated differently. Professor van der Spuy's personal attention and sympathy made Roxanne more assertive in her treatment-seeking behaviour. In addition she could phone the nurse in charge whenever she had a problem. This was not preferential treatment. In fact Roxanne received the quality of care that should be the right of all women. Still, even then, Roxanne complained that waiting for treatment was time-consuming. Sometimes she felt very frustrated while attending the Infertility Clinic, because the procedures took so long. Overall though, Roxanne's experiences at the facility were predominantly satisfactory, resulting in the birth of her son.

Two years later, Roxanne and her husband decided that it was time for another child. Once again she was unable to conceive, and was again able to gain access to the Infertility Clinic fairly easily. This time she was told that she would only be eligible for treatment once she had lost between ten and fifteen kilograms. Though she did not receive treatment immediately, her good relationship with the staff at the facility continued. Professor van der Spuy asked Roxanne to speak to her students about her experience with infertility. She also participated in a pharmaceutical trial for a weight-loss tablet. Roxanne has also remained in contact with some of the nurses from the Infertility Clinic.

Whilst Roxanne's journey at the Infertility Clinic was ending eight years ago, Veon's journey was just beginning. She was nineteen years old when she was married. After trying to conceive for six months without success, her mother advised her to seek treatment at Groote Schuur's Infertility Clinic. This was seen as her only affordable

option. Veon said that if her mother had not advised her, she would not have known where to go to seek treatment. Veon and her mother both assumed that they would be able to get information about the facility at any maternity ward, but this was not the case. She was also unable to gain adequate information from the family planning nurse at her local clinic. She was told that she would have to phone the facility herself to schedule an appointment, but would need a private doctor's referral letter first.

She found it very difficult to gain access to the Infertility Clinic. First she had to meet very stringent requirements. She had to show her marriage certificate, her identity document and her husband's identity document to the practitioner at her first consultation. The nursing staff at the Infertility Clinic said that she had to be married for a year before she was eligible for treatment. She said that the nurses showed no empathy. They questioned her about her life in a manner that she found discriminating and belittling. Nurses asked her, "What are you looking for here?" or would say to her in a dismissive manner that, "You have to be married", before she could even tell them that she was married. This was followed by questions such as, "Why did you get married so young?" She said that the nurses' attitude did not encourage her to return to the Infertility Clinic.

However, Veon waited until she had been married for a year and then returned to the Infertility Clinic. A gynaecologist performed a Pap smear and scheduled another appointment. Veon said that she found the three-month wait between appointments particularly difficult. When she returned, her Pap smear results had not been received, and nothing further could be done without them. A year after the Pap smear was performed she received the results in a letter. The letter stated that she should

schedule another appointment because an abnormality had been detected. By that time Veon's marriage was collapsing, and she decided to have the follow-up Pap smear done by a private doctor. The results of this test indicated no abnormalities.

Veon said that the Infertility Clinic lacked sufficient medical staff. She says there were too many students working at the facility, whom she claimed were inadequately supervised. Secondly, the treatment at the Infertility Clinic was expensive. While Veon did not personally undergo treatment, she said that a friend spent R15 000 on treatment in one year. There were times when her friend had to report daily for 'fertility injections' that cost R1000 each. Veon thought it was unreasonable to expect women to pay that amount of money. She said that the treatment one receives from healthcare providers there is sub-standard. She also says that the Infertility Clinic should provide more affordable treatment because it is a public health facility. Veon's severe criticism supports her perception that infertility treatment should be a right for all women regardless of cost. - Even poor women should be able to afford it because it is a public health service. She said that her friend's experiences indicate that poor women are not treated with much respect in this sector. Whilst Veon's severe critique of the Infertility Clinic is unfounded, ultimately they illustrate a poor perception of the public health care sector that prevail.

Veon was so disappointed by her treatment at the Infertility Clinic eight years ago that she vowed never to return. She even blames the staff at the facility for her childlessness. She argues that if she had received adequate treatment then, she would have had more than one child by now.

These two stories describe very different experiences at the same facility.

They illustrate that while we live in a society that champions equality; all people are not treated equally, especially in the public health sector. Inequality can manifest itself wherever there is competition among human beings to receive much-needed, life-altering treatment. In this case, the attitude of individual healthcare professionals made all the difference between Roxanne's perception of excellent treatment and Veon's perception of poor treatment. Financial constraints also influence the perception of treatment. Although I do not know how much money Roxanne spent on treatment, she perceived the cost to be fair. Veon, on the other hand, considered the cost excessive. Even though Veon thought the treatment at the Infertility Clinic too expensive, she chose to seek treatment in the private sector, which is known to be excessive. Her view namely that one will receive the best care in the private sector is widely held on the Cape Flats. However, she realised that the 'best' care comes at a cost that is ultimately unaffordable.

Desiree was the only one of the other participants who did not know where to access treatment for infertility in the public health sector. Sarah said that information available about public health sector treatment abounds. However, she says that she doesn't pay attention to this information, because she tends not to talk about infertility and is not ready to face up to it. On the other hand, Angel argues that there is insufficient information available about where to access treatment in the public sector. She said that she would not have known about the Infertility Clinic if a relative had not advised her of it.

Sarah is hesitant about using the public healthcare sector, because she does not have faith in infertility treatment from this sector. She also avoids seeking help because she

doesn't want to create false expectations for herself or her husband. She complained about the lack of patient/staff confidentiality at public health facilities. She says that while health providers assure patients their details will remain confidential; this is not actually the case. "There's no telling whether that sister might tell the next person, "Do you know that the woman that was here before you wants a letter for the Infertility Clinic? She probably can't have children on her own." She said that the news that she is infertile could filter back to her family via the local gossip network.

While the public health sector treatment is often the only option for infertile women, the treatment offered does not always live up to their expectations. The Infertility Clinic services have been adversely affected by the problems in the wider healthcare system. Policymakers are aware of the need for infertility services (and for adequate services in general), but they have been unable to meet the demand. The Infertility Clinic is a beacon of hope for the majority of infertile women on the Cape Flats, but for many it will remain just that. Because it is so under-resourced, not all the women who qualify for the treatment they desperately need, will actually receive it.

### **5.2.2 The private health sector**

Moore and Zimbizi (1996) state that private medicine is only available to a privileged few. Most South Africans with access to the private health sector, do so through medical aid schemes. However, private health care does not present any real solutions to the problems of health care provision in South Africa, because only one fifth of South Africans are able to access it (SAIRR 2006). Some of the participants in this study consider themselves to be part of the 'other' four fifths. Veon, Angel and Sarah all say that the private health care sector is accessible to the privileged, because the cost is too high for them.

These participants aspire to become part of that elite group of wealthier citizens so that they can access medical treatment. For working-class infertile women, the privileges of the middle-class are even more apparent when considering health care. These factors only serve to increase the participants' sense of desperation and injustice about their infertility treatment.

Though Veon is one of the participants who believe that the private health sector is only for the privileged, she would go to any length to receive treatment. Despite ongoing financial difficulties, she now makes adequate financial plans to access health care treatment in the private sector, because she believes she will receive better treatment there. After Veon's second marriage, she was still unable to obtain treatment even though her husband was a member of a medical aid scheme. The medical aid scheme will only fund reproductive health consultations after a year of membership. Until then, she is unable to afford R120 for a consultation, R170 for a Pap smear, or R600 for a gynaecologist's consultation. Some would argue that given her financial situation she would not be able to support a child. However such questions are rarely asked of fertile women.

Sarah and Angle rarely use the private health sector for assistance with reproductive health. Sarah consults with her GP only when she is generally unwell. She has had a Pap smear done during one such consultation. However, she usually goes for Pap smears at the public healthcare facility. Angel only makes use of a private doctor only when she needs a medical certificate. Angel and Sarah's refusal to access treatment for infertility in the private sector illustrates that their knowledge of the high cost involved prevent them from using this sector.

The participants make use of the private health sector only when they feel that they need 'special' medical treatment. Sometimes they seek help from a private GP because they think that their treatment of general ailments is best. However, they can only make use of this sector if they have the financial resources to do so. Even Desiree, who has medical aid, is hesitant about using the private sector because of the associated costs. In general, these women's attempts to meet private sector costs for infertility treatment are unsuccessful. They cannot afford the high number of follow-up visits to ensure conception.

#### **Private infertility treatment and community prejudice:**

In this section I provide a brief description of the treatment process women have to undergo in the private sector, in their quest for conception. Dr Bruce Howard, a gynaecologist in private practice explained the process briefly. He said that an infertile woman wanting private sector treatment starts by visiting a gynaecologist. If the patient has not yet been diagnosed, the gynaecologist has to identify the cause of the woman's infertility, firstly by asking questions and then by a physical examination. This includes examination of the thyroid, breasts and abdominal area, and an internal and external ultra-sound. If the problem cannot be identified at that stage, or diagnosis cannot be confirmed, the patient is advised to have blood tests. If the blood tests do not reveal any hormonal imbalances or any other abnormalities, the patient is hospitalised for a laparoscopy to physically inspect the reproductive organs for any obstructions. Once the cause of the infertility is identified, the gynaecologist will either start the patient on fertility drugs or treat the problem in some other way.



Depending on the severity of the patient's condition, the gynaecologist will either continue treatment or refer the patient to a fertility specialist.

In the private health sector, reproductive health is maintained through regular consultation with a gynaecologist. This not as simple as it appears. Veon is the only participant who tries to consult a gynaecologist regularly. However her financial situation determines the regularity of her visits. The other participants, including the woman that has been diagnosed, are not as keen to visit private gynaecologists. Sarah has never consulted a gynaecologist, mainly because of cost: "If that man tells you that his fee is R800, R900, if you earn R2500 to R3000, which is a lot of money to just be chucking away like that. I must tell my neighbour I went to the gynaecologist. She will then ask how much I paid. If I say R800, R900, she will tell me I am crazy to pay R800, R900 rand to sort out my problem..." Angel expressed the same sentiment. Generally, fertility is perceived as a natural function of a woman's reproduction. Thus, on the Cape Flats the idea that one would spend money to ensure conception is considered to be preposterous. Most would consider such resources better spent to obtain other household goods. In this manner, the problem of infertility is stigmatized and silences. Once again this illustrates the economic value attached to fertility.

Roxanne has been medically diagnosed as infertile, and Desiree has been diagnosed with endometriosis. However, neither has seen a gynaecologist for a very long time. Roxanne has not consulted a gynaecologist since the birth of her son, seven years ago. She said that she was a patient at the Infertility Clinic and she saw the best doctors. She said that consulting with a private gynaecologist after the birth of her son was too expensive. In the past, Desiree consulted a gynaecologist annually. For the past two years she has not been able to afford it.

The private health sector is mainly accessible only to women with medical aid benefits. Costs vary from at a cost of R400-R700 for a consultation fee, R300-R700 for an ultra-sound, and R300-R1000 for blood tests and R14000 for a laparoscopy. In addition, most gynaecologists demand payment immediately after a consultation. Patients then have to apply to their medical aid scheme for a refund. For most of the participants, such access to ready cash is not possible. Thus, even women such as Veon who believe that membership of a medical aid scheme will facilitate access to treatment are confronted with unforeseen financial difficulties. A very small number of infertile women have access to the private sector in South Africa. Although most hospitalisation and medication costs are covered by medical aid, repeat visits to a gynaecologist are not. What then are the chances that an ordinary South African woman could pay R25 000 for one IVF cycle?

Access to medical treatment in the private sector was only briefly dealt with in this chapter, because most of the women interviewed see this sector as inaccessible, and none have actually received private sector fertility-enhancing treatment. Yet most of the women considered treatment for infertility in the private sector to be better than in the public sector. This is despite the fact that the Infertility Clinic, a public sector facility, is well equipped and uses state-of-the-art treatment methods. Clearly, prejudice about the public health care sector is an additional barrier. Financial constraints posed the biggest obstacle in accessing treatment in the private health care sector. The social perception that expenditure on infertility treatment is self-indulgent acts as an additional, powerful deterrent to women in this situation.

Most of the complaints about difficulties in accessing treatment were directed at the public health sector. The private health sector is not without its problems, but for most infertile women, it is a light at the end of the tunnel that remains just out of reach.

### **5.3 WHEN THERE IS NO MORE HOPE**

When medical treatment fails, what options do infertile women have? Dr. Dyer of the Infertility Clinic says that if treatment is unsuccessful at the Clinic there is no hope that the patient will ever conceive, because the doctors will try all the available treatment before giving up. If they are unable to help a woman conceive, she either has to accept her condition or consider adoption. Desiree and Angel both stated that they had accepted their infertile status; yet these two women still cling to the hope that one day they will be mothers.

During her first marriage, Veon and her husband fostered a baby boy. Veon knew of an elderly woman in her community who was fostering her grandchildren because their mother was unable to care for them. The woman's daughter was pregnant again, and it was arranged for Veon and her husband to foster the child, with the possibility of adoption. Veon reared the baby from the age of two months until he was eight months old. She says the baby was very sickly when he came to her and she nursed him back to health. She described those six months as the happiest of her life. When Veon went to the grandmother to discuss starting the adoption process, she was told that she could no longer adopt the baby.

After the heartbreak of her first fostering experience, Veon is very hesitant about seeking adoption. Veon's second husband however, has said he is willing to adopt if

they are unable to have their own children. She says that there is too much bureaucratic red tape to work through. Veon felt that 'the system' is more concerned with logistical issues than placing a child in a loving home. After her experience, she would prefer to have her own children, but if that proves impossible she would consider adoption.

Adoption is a complicated and time-consuming process. Bellina and Wilson (1986) state that there are fewer babies to adopt due to the increasing effectiveness of contraceptives, the availability of abortions and because more women are opting to rear their children as single mothers. Single motherhood is no longer as stigmatised as in the past. Adoption agencies in South Africa have very strict criteria with which prospective parents have to comply. Adoption cannot be entered into lightly. Too many women, including most of the participants, assume that there is a multitude of newborn babies waiting to be adopted. Actually there is a shortage, because most infertile couples want to adopt newborn babies. Furthermore, adoption should not necessarily be seen as a viable option for all the participants, whether or not they would consider it; Bellina and Wilson (1986) state that it is important that the decision to pursue adoption is taken by both partners, that they have dealt with their childlessness, and that they view adoption as a means to create the family that they long for. If an infertile woman has any doubts about whether she would love an adopted child the same as a biological child, or if there is any feeling that an adopted child will be only 'second best', then adoption should not be considered.

The informants' opinions about adoption varied. Angel would not consider adoption, but would or could not give a reason. Roxanne also rejected this option because of her husband's attitude towards it. While she was struggling to conceive their first child,

she asked her husband if it wouldn't be easier to adopt. He refused, insisting that they had to have their own child. Desiree does see adoption as an option if she is unable to have her own child. However, she does not think that she and her husband would choose this route because the process is too long. Sarah's husband is against adoption and she is hesitant to discuss the subject with him.

Few of my informants would consider adoption as a viable option. In the meantime all the informants still hope they would be able to bear their own children.

### **Conclusion:**

In this chapter, I explored access to medical resources for infertile women from the Cape Flats.

The participants' experiences illustrate the resilience and determination that infertile women have to possess if they want to access medical treatment in South Africa. In the public health sector, infertility treatment is hampered firstly by the lack of resources and by specialised-care facilities. The Infertility Clinic at Groote Schuur Hospital does address the problem but is unable to meet the needs of many infertile women because the clinic is under-resourced, and many women remain ignorant of the services offered at the facility. Their access is also hampered by poor advice they receive from nurses at referral centres. They are not always made aware that infertility treatment is available at the Infertility Clinic. However, seeing that the Infertility Clinic is a public health facility, there is a perception that the treatment infertile women receive here is substandard.

Most infertile women also have social prejudices about the efficacy of treatment in the public health sector. Infertility treatment in the private sector is perceived as the best, but remains unattainable for most women because of cost. However, for infertility treatment, high cost is not restricted to the private health sector. The economic cost of fertility treatment is a real burden. However, for women who want to become mothers at any cost, there is room to negotiate their access to treatment.

In the following chapter, I explore the social and cultural constructions of infertility on the Cape Flats.

## **CHAPTER 6: 'TJOEKOE DING'- HOW CAPE FLATS COMMUNITIES CONSTRUCT INFERTILE WOMEN**

Gossip and the resulting stigmatisation are the most feared effects of infertility on the Cape Flats. Biological motherhood bestows social status and cultural power to women who conform to the dominant ideology of motherhood. Infertile women on the Cape Flats are constructed as the deviant 'other'. They are seen as deviant because they diverge from the status quo that expects all women should become 'natural' mothers (Salo, 2004). When women are unable to fulfil the expectation of becoming 'natural' mothers, these communities struggle to grasp the possibility of infertility. They cannot imagine where infertile women fit into society. There are few alternative means through which cultural power and social status can be bestowed upon them. Consequently, infertile women are stigmatised even though their non-conformance is involuntary. They become socially invisible and are denied access to the social status and rewards associated with motherhood. On the Cape Flats, an unspoken rule exists that who deviates from the social norm is constructed as deviant. These individuals are shrouded in silence, and stigmatised when an attempt is made to talk about infertility publicly. Regardless of whether a woman is actually infertile or not, the suspicion of infertility carries social consequences which can be devastating. These infertile women are constructed as lesser beings, as incomplete persons. Veon's story, below illustrates the social effects of infertility.

### **6.1 VEON'S STORY**

"I was nineteen when I got married the first time. We gave ourselves space for about six months before we were going to start a family. At the end of the six months, I

could see changes in his behaviour and things like that because normally people think that naturally in the first two months, something should be there. After the six months, I consulted Groote Schuur's Infertility Clinic. Then they told me that I should be married for a year before they could assist me. Okay, then I waited that year but during that year that we were married... I mean a lot of people told me, 'Nah, you not a woman', or, 'What's wrong with you because so many people have babies, like and... like, in the first two months or three months, and look, you almost married a year already.' And then the abuse from my father-in-law started. He used to tease me; he used to tell me, 'Yes, maybe my son should go with someone else just to have a baby'. Things like that and, I mean, the way it made me feel like a failure. Okay, and then after the year, I went back. Okay, they gave me a Pap smear and gave me another appointment. They gave me another appointment three months after that one. *AFTER A YEAR*, then they sent me the results of the Pap smear saying that I should go for another Pap smear because they detected something. I went privately and the Pap smear came back negative, nothing was wrong. And that was the last six months of the marriage."

For a while Veon dismissed the mean comments, and thought that it would all blow over, but it became worse.

"I can recall when we went to Sandvlei. We had a little picnic there, and then, as I was lying in the sun, my father-in-law, my husband, ex-husband and his sister started the teasing again. And I just pretended to ignore them. They said things like 'Daa' lê die tjoekoe'<sup>20</sup> (There lies the tjoekoe), things like that, and, 'maybe you not doing her right'. You know, it sounds bad as it is. But I mean it sounds petty. I just ignored it.

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<sup>20</sup> Roughly translates as 'a defective firecracker', implying that an infertile woman is defective.



And I recall I was lying on my tummy and I just felt this stabbing pain, but then it was my father-in-law jumping on my back. So I didn't know he was going to do that, so naturally I didn't tense up or anything. And then he said, 'Ag, man it won't cause any damage, because you are damaged goods already.' I left it. I spoke to my husband about it and he just dismissed it."

It was difficult for Veon to see how her husband, who should have comforted and protected her, could condone this abuse and take part in it.

During their marriage her husband also had affairs. He never admitted to it but during their marriage she noticed changes in his behaviour. He became more aggressive; he did not come home when he was expected, he would stay out over weekends and did not want his wife to spend time with his family. He came home with 'love bites' on his neck and treated her with total disrespect.

"Okay, then I didn't know he had someone on the side. One evening, he just stayed out. It was a Friday and he came back home the MONDAY. I wasn't one to say anything about it or to complain. I told him, 'No man, I don't think this is going to work out, I'll rather just move back to my mother's place.' And then the crocodile tears came and the crying and the begging and the kneeling on the floor. Then I thought, okay, I mean it's my husband. I thought okay, fine, and then we did the DEED. But I'm telling you, I didn't know that he came from somebody else. He didn't even have the decency to go and wash or whatever, I mean. And afterwards, I only found out. So we did the deed and I'm telling you, the evening I had such pain, I can't describe it. I couldn't move, I couldn't get up, couldn't even CRY properly because of the pain and I've never experienced anything like that before. And funny enough I only found out about this a year ago, A YEAR AGO... A year ago, I only found this out. I told him

that something wasn't right inside and HE WAS SO SUPPORTIVE for the first week, you won't imagine. And I suspected it but I didn't have proof or anything. Then the beating came. He use to beat me and say words like, 'You can't even give me a child', 'You are damaged goods', and 'I don't know why I got married to you' because you... you know, it was just about the baby, it was the baby, the baby thing, the baby thing. And then after a while I said to myself 'No, I'm not going to take this anymore because I'm worth much more than that.'

"And it took me a while to leave him but I moved in with my friend's parents. They actually HID me from him. After two weeks, as I came from work, the first job after I left him, he was sitting there. And the crocodile tears came again but by that time, I just lost all love and affection for him. I reminded myself of the words that they said to me, the way he beat me. They way they, the whole family treated me and I just said, 'No, I'm not going back' and I never did."

After her divorce, she had one brief relationship before entering into a long-term relationship. During the second year in the long-term relationship, the couple tried to conceive. They were not using contraceptives but she was still unable to conceive. Her partner was very supportive. The relationship progressed well until their friends began asking questions about their inability to conceive. Veon began avoiding her friends to avoid the persistent questions- "'when are you going to have a baby? Don't you have a baby yet? Why aren't you pregnant yet?' I mean things like that and I'm older than them. And then the friends started '*Haai, het julle nogie 'n baby ie? Hoe lank gan julle nou al uit al?*' (Don't you have a baby yet? How long have you been going out?). I just couldn't take it because I mean, I wasn't getting any younger either."

These questions reminded her of the pressure she felt during her first marriage. In an attempt to escape, she started partying. Veon separated from her second partner after four years.

In June 2005, she met her new partner. While they were dating, she told him about her inability to conceive. Despite her confession, they were married in February 2006.

During the early days of their marriage, "There were many nights when I use to cry and tell him, 'I know we are only married for a month but this is not a feeling that I've been having for a month. It's been years already and I just feel... I just feel like a *REJECT*, because why, between all my sisters, my mother and the *WHOLE* of my family, they all have kids but I don't. What is so special about them? What do I lack that they have?'"

The trauma suffered in her first marriage continued to manifest itself in her second marriage. She says that "I've thought of going to counselling. Then I just think it's a waste because what is that going to do? I'm not shy to say what happened to me or anything like that. But it's not going to bring that person back. The suspicions never stop. Will he do this? I know he loves me but what is going to keep him from doing this? Sometimes I start an argument, just for the fun of it. Just because I want that attention and I want to see how far I can push. Even with my husband now, I tend to do things and then I just want see how far I can push him. And if he will, like, hit me or do something, man. But he's never hit me and he will always say 'you can hit me'. Once I smacked him. Till this day I feel bad about doing it. Because I didn't like it, what my ex done to me.

"My husband then told me, 'You can hit me but I'm not going to do that. I'm not going to lower myself to what was done to you and now you passing it on to me. Just

remember that if you should continue with this and our marriage does end, it is because you are living in your past.' And that made me think a lot about what happened in my past. And I'm actually doing that. I'm doing it but I actually DON'T WANT TO DO IT. And even argument and things like that. I'm doing it because that is how I felt and now I want everybody to pay but it's not really what I want. I know all these things but to control it... But sometimes I have nothing to feel positive about or not seeing any good, really. Sometimes you think, what is positive about today? But I mean sometimes you just feel, what is life dishing out at me? If I do feel sad about it, then I pray and I say, 'but that was in my past'. God has a plan and I believe that I will have a baby but in God's own time..."

Veon's story shows the severe physical and emotional abuse that she suffered because she was unable to conceive. This is not an uncommon experience. Dyer et al (Human Reproduction, 2005) conducted a study to measure the psychological distress among women suffering from couple infertility. They drew a link between psychological distress, abuse and infertility. They concluded that infertile women in abusive relationships experience a higher level of psychological distress than infertile women in non-abusive relationships. Veon was blamed for the couple's infertility during her first marriage, because of the community held the belief that infertility is a woman's problem. Neither she nor her husband explored the causes of infertility; they both assumed that she was infertile. This belief was common to all her relationships.

Veon's story also illustrates the loss of personhood mentioned earlier. She was constructed as a lesser person by her husband's family through the use of derogatory terms and snide remarks. Her 'deviant' status was also noted by her friends and family, also defined her as deviant as they constantly asked questions her about her inability

to conceive. Veon has internalised this negative image that has caused her emotional anguish.

In this chapter, I will address the social consequences of infertility, firstly by looking at how social stigma is perpetuated in the communities of the Cape Flats. I will show how women face social exclusion and isolation through the terms used to label infertile women and through gossip. Secondly, I will show how infertile women's lack of status and power associated with motherhood affects their relationships with other women in their communities. Thirdly, I will examine social beliefs about the causes of infertility and how these beliefs compound the social stigmatisation of infertile women. I describe the emotional anguish that infertile women experience as they internalise the negative image associated with their condition. Finally I examine the role of infertile women's partners as they support (or fail to support), and how their support (or lack thereof) influences the women's search for treatment

Motherhood is important to working-class women. It is important therefore to explore the cultural constructions of infertility and the implications of the stigma attached to it. A woman's moral career is dependent on her transition from good daughter to respectable mother. Roxanne, Desiree, Veon, Aquifa and Sarah progressed from being good daughters in their parental home to adulthood through clean marriages<sup>21</sup> Roxanne and Veon were the virginal brides, and all these women entered into marriage with no children. Angel is the only participant who is not married and who has no plans to marry. However, even she is categorised as failing to attain the most

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<sup>21</sup> 'Clean marriage' is a term used by Salo (2004) to refer to a marriage without illegitimate children.

important social status a woman can have on the Cape Flats, namely motherhood.

Roxanne is the only participant to have achieved this status. She has given birth to a son, and she does not see herself as being negatively influenced by the cultural prescriptions held on the Cape Flats. These prescriptions carry enormous cultural weight. In a patriarchal society such as ours, childbearing is the keystone of womanhood.

It was therefore surprising that most of the participants said they preferred to give birth to daughters, given the value placed on sons. Roxanne said that she has always dreamed of having a daughter. While she has proved her womanhood through bearing a child, she is expected to bear more children. Failure to conform to the dominant social and cultural construction of motherhood holds severe consequences for infertile women. Most significantly they lose cultural power within a community because mothers are culturally assigned the power to control the very lives of their communities.

Inhorn (1996) states that fertility is recognised as one of women's strongest sources of power. Infertility threatens the status quo by denying infertile women access to this power. A woman's infertility negatively affects her image in the eyes of her husband, family and community. Female infertility also threatens men's social power because their failure to have children nullifies the male claim to fertility, procreativity and continuing the family name. Inhorn (1996) states, the patriarchal fertility mandate prescribes that all women are expected to become wives and mothers. This mandate prescribes motherhood as the sole key social identity to which all women should aspire. Indicating the enormous cultural consequences of childlessness, Anne Oakley (1980:183) states, "Without a child to call her own, a woman in our culture falls short

of cultural expectation. She has not achieved the standard that is set for all biologically female persons in that (a) she has not given birth and (b) she has not entered the feminine domestic triad wife-husband-child. Of course the standard that equates womanhood with reproduction is differently expressed and adhered to among different social groups. But the idea that only women with children are 'proper' women is remarkably pervasive even in the days of public commitment to sex equality." As I show below, the process of stigmatisation of infertile women not only reinforces widely held values of mandatory reproduction, but also exacerbates the infertile women's anguish because she is considered socially dead - she is only acknowledged when she is the object of insult or gossip.

## **6.2 STIGMATISATION**

The anguish of infertility is made worse by the stigmatisation of infertility in the social contexts where infertile women reside. The stigma of infertility is a regular, everyday feature created often by those closest to these women, such as their husbands, their relatives, friends and neighbours as Angel's story illustrates. At the time this occurred, Angel was not involved in a relationship. One Sunday afternoon, Angel's brother was drinking at a neighbour's house. When it grew late, she reminded him that it was a work day the next day. The next day the neighbour, who was drunk at the time, came over to her house and told her, "*Djy's bad luck. Ja, djy kan nie 'n man kry nie. Djy kan nie kinnars kry nie.*" (You're bad luck. Yes, you can't get a man. You can't even have children.) Here Angel's infertility was blamed as the cause of ending a weekend drinking session.

Veon's even claims that infertile women did something to 'piss off God' because childbearing is the most natural experience. Her belief that her infertility is a

punishment from God was reinforced when she sought prayer from a local pastor. He told her that she was cursed because she divorced her first husband. Because of this curse, evil is produced when she has sexual intercourse with her second husband. He said that God will not sanction conception in her second marriage.

People on the Cape Flats do not expect infertility to exist in their communities, or even in their families. If a woman is infertile, she is maligned in the same way as someone with a deadly, infectious disease. She says that she cannot be perceived to be a complete woman, because she hasn't borne a child. The focus group participants, who were mothers, indicated that infertility is seen as a disease. Most people fear or avoid infertile women.

The rest of the participants from the infertility group also said that infertility is severely stigmatised on the Cape Flats. Angel said that stigmatisation is worse in working-class communities. Roxanne echoed Angel's sentiment, while Desiree thinks that infertile women are afraid to disclose their status because of the accompanying stigma.

Even the suspicion of infertility is sufficient to lead to the immediate stigmatisation of a woman in these communities. Sister October of Manenberg Clinic states that according to popular belief, if a woman does not conceive after a month of unprotected intercourse, she is socially defined as infertile. This perception is widely held by both men and women. However, it is men's assessment that carries most weight. Sister October had observed that some women would come to the clinic two or three times a month for a pregnancy test. When questioned about the frequent visits, they said *"Niee, Sister ek wiet nie, ek is sieker infertile. My man sê ek is infertile."* (No, Sister, I don't know, I'm probably infertile. My husband says I'm



infertile). She says that in most cases, this was not true. These women, she said, are ignorant about the influence of contraceptives on fertility. For example, the chemical effects of injectable contraceptives disappear only after six to nine months. Sister October commented that women's need to conceive is also fuelled by a need to prove their fertility to other women. In Manenberg many will pass snide comments about a woman who is perceived to be infertile. This perception is primarily created through gossip. The taunting comes from the husband, family and friends, who will say "*Niee, wat's verkeerd met jou?*" (What's wrong with you?). They assume there is 'something wrong' if a woman cannot conceive immediately.

Similarly, Inhorn (1996) found that poor, infertile women in Egypt are also severely stigmatised. The social identity of 'poor, infertile woman' is one of the least desirable identities in this society. This identity has all the classic features of stigma as defined by Erving Goffman (1963:12). He defined stigma "as an attribute that makes him different from others in the category of persons available for him to be and of a less desirable kin – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting affect is very extensive, sometimes it is also called a failing, a shortcoming, a handicap."

Gossip is the primary means of stigmatisation.

#### **6.2.1. The pain of gossip**

Gossip is used to police women's behaviour on the Cape Flats, and also to construct the image of the infertile woman. It is used to reinforce the norm of motherhood and to isolate those who are perceived to deviate from this norm. The threat of being the topic of gossip in the community has caused the participants to be extremely discreet

about their infertile status. Moreover stigma has contributed to the silencing of open discussion of infertility on the Cape Flats. Women are fearful of disclosing their infertile status because they fear the judgment of their neighbours and the resultant social isolation. Veon points out that the threat of victimisation does not always come from within a marriage, because a husband and wife can deal with infertility as a couple. It is most powerful outside the marriage. Friends, family and the community can have a negative impact on a couple's ability to deal with infertility. The community gossip mill can even turn a husband against his wife, leading him to question her reasons for not conceiving. Perceptions are powerful; Veon fears that if she is not able to have a child, her husband will father a child with another woman.

Angel does not want to disclose her infertile status because she feels that it is a personal issue and she does not want to be judged. There is no sympathy for infertile women, only gossip about them. Gossip occurs even at her workplace.

Veon discusses her infertility with her mother and sisters, but only to a limited extent. Her sisters do not discuss her infertility in detail with her because they have never struggled to conceive. She said of the rest of the community that "It's like when people say, '*Haai, het djy nog nie 'n baby nie?*' (Don't you have a baby yet?). I'm like, 'No, I'm not planning, we not planning on it immediately because we need this and we need that.' So I mean that is what I tell them and that's why I draw the line there."

Furthermore, Veon claimed that mothers especially will not directly make comments to her, but Veon knows that they gossip about her. If she leaves the room, when she comes back all the women stop talking and go quiet. She knows that the gossip is mostly about the cause of her infertility. She says that people do gossip about her because one is expected to conceive soon after marriage. This is her second marriage

and she is still unable to bear a child. Angel also said that it is mainly mothers who gossip about infertile women. These women do so because they say that they are superior to infertile women because they have children.

Sarah is aware that a woman's suspected infertility becomes a juicy gossip story in her community. The threat of being exposed as infertile is one of the reasons why she has not sought treatment.

Generally, Desiree does not discuss her infertility with anyone. She does discuss her infertility with family and some friends because they have been supportive. When people outside her support network ask her when she will have children, she replies, "When the Lord allows it to happen." She feels that this is an appropriate answer for people who do not know her situation. Her refusal to talk about her situation provides her with protection against gossip. She says that some people only ask infertile women questions about their infertility to fuel gossip.

However some sympathy for infertile women does exist amongst the women on the Cape Flats. The mothers from the focus group said that gossips abound about infertile women, especially if they are married or in long term relationships and they do not have children. The comments are extremely hurtful. People always put blame on the woman even if she is not the cause of the inability to conceive. They felt that women were unfairly blamed for their infertility.

Roxanne is very open about her infertility. "I don't mind talking about it, 'cause if what I went through can help the next person, because I know what it's like to want and not to have, and not being able to..." However, she has cocooned herself within her family and does not discuss her condition with anyone else.

Hardcastle (2005) states that gossip is by far the most common social weapon.

Though some gossip may help a person's reputation, most is mean-spirited and harmful. Gossip acquires a sinister nature because it is done to isolate the individual who is the subject. The most common type of gossip is the passing on of stories that are pitiful, but almost believable. As these infertile participants' stories show, the most difficult aspect of gossip is proving or disproving these rumours. The gossip directed at infertile women is indeed mean-spirited because they, the victims are held responsible for their situation. People speculate about what they did wrong that caused their infertility. The participants experienced social exclusion and isolation during their interaction with other women especially those who are mothers in their communities.

While the participants self-identified as infertile and it is not known if they actually are or not, the fact that they have not borne children fuels the rumour mill. Supporting the theory that gossip operates within a social network, Adam Ashforth (2005:66) states, "The psychological essence of gossip is the desire for secret knowledge about other people, especially their vices and fallings. The coin of gossip is authentic 'inside' information indiscreetly revealed... The right of gossip is the 'hallmark' of membership of a group, refusal to gossip is the denial of membership and the practice of gossip over time serves to 'unite' a group within a larger society, or against another group." Through gossip infertile women are unable to become full members of the group of 'adult' women. Their childlessness positions infertile women in opposition to mothers, who are more powerful in their communities. Mothers use their power to isolate infertile women because their failure to conceive is a challenge to the status quo. Motherhood bestows social status upon a woman, and this social power is used

to police the behaviour of other women in order to reinforce the ideology of motherhood.

### 6.2.2 Power of words

On the Cape Flats, where the dominant languages are English and Afrikaans, there is the terms 'mummy', 'mommy', 'mamma', 'mom', 'ma', 'mie' and others are used to refer to mothers, and serve to distinguish them from their childless counterparts. These different terms for motherhood, validates its status. Similarly, a discourse exists to signify the deviant status of the infertile woman. The use of derogatory words also reinforces the stigmatization of infertility.

Sister October knows of two terms used to describe infertile women in the communities of the Cape Flats. One is '*tjoekoe*', which translates roughly as 'a defective firecracker', implying that an infertile woman is defective. The other is '*sy kan nie staan nie*' (she cannot stand on her own). While this term is used to describe a woman who cannot conceive, the literal meaning of the words implies that she cannot stand alone as an independent, adult person. She is still a child. Sister October said that some women introduced their unfortunate friends with the words, "*Sister, sy's mos ie' een wat ie' kan staan'ie*" (Sister, she's the one that cannot stand [i.e., fall pregnant]), or "*Haar man sê sy is 'n tjoekoe*" (Her husband says she is a *tjoekoe*). The participants in this study had also heard these terms. The mothers from the focus group reported that the term *tjoekoe* is most often used to refer to infertile women. Various other more vulgar terms are also used. However, their essential crudity shows the contempt in which infertile women are held.

Desiree pointed out that the tone of voice, more so than the words used imply stigma. Just saying, "You can't even have children" implies that a woman is seen as less of a

woman and less of a human being. The focus group participants supported Desiree's view. Angel also agreed that a woman's infertility can be used against her, to insult her. Thus, the infertile are not only victimised through derogatory language, but sometimes simply in the manner that ordinary words are used with malicious intent.

Veon, Desiree and Angel maintain that infertile women are victimised not only by what people say to them, but how they are treated. Mothers exclude them from the conversation by only talking about babies or child-related issues. They say that they feel that they have no power and no right to participate in the conversation because they aren't mothers. Being a mother gives one the right to impose one's views on childless women. This social exclusion can occur in any situation, when they are with friends, at parties, or at work. Roxanne is the only one of the participants who has not experienced this exclusion, because she has a child. However, she is still questioned about her inability to have more children.

The comments and negative behaviour directed at infertile women go deeper than is at first apparent. They are an attempt to construct the infertile as deviant to the norm.

Lasker and Borg (1989:13) state that the pressure to conceive a child is "deeply embedded in culture, supported in powerful social norms. Every culture has its ideal image of what a man and woman should be like, and for the woman, the cultural ideal is almost always on motherhood." Infertile women lack such social and cultural status in their communities.

### **6.3. LACK OF STATUS**

The women's inability to bear children prevents them from progressing onto the adult phase in the life cycle. The good daughter cannot become the respectable mother

through childbirth (Salo, 2004). The physical inability to produce children holds implications for women's respectability and the position or status that they hold in their communities. It is universally accepted firstly that a woman's identity changes with the birth of her first child; as a mother she is revered by society. Secondly, womanhood is proven through fertility, thus childbearing gives a woman the identity of a 'true woman'. The participants in this study all supported the argument that motherhood gives a woman status in the communities of the Cape Flats.

Veon said that motherhood gives a woman status among other mothers as well as among other women in her community. An infertile woman is less respected and has less power than her fertile counterpart. Because she does not have children, she has no say in family matters, and no right to reprimand another woman's child.

Marriage does not protect the infertile woman, because it does not erase her childlessness. Angel states that in her community childbearing is used to determine womanhood. If one does not have children, one is not a woman. She goes on to say that childbearing is not the sole indicator of womanhood; and that womanhood is dependent on childbearing occurring within the ideal context of marriage.

Normally, older women are given senior status in a community. However, a childless older woman is robbed of this status. Angel argues that a sixteen-year-old mother has more status in the community than she does as a forty-year-old, unmarried, childless woman. Veon reports that in her community, too, women younger than she is have more status simply because they are mothers. Veon's niece, who had a baby at sixteen, has always belittled Veon because she does not have children.

Veon says: "Wow, I got nothing and she has everything. And then once I told her, 'You might have kids, but remember it's from different men. First of all, I am married, so I am allowed to have kids. *Ek het nie vir jou gesê maak jou bene oep nie* (I didn't tell you to open your legs)'. And that started, like, a whole thing. And we didn't speak to each other for a while. But then afterwards she started again, because I just felt... she is 'dissing' me on every corner and I'm just sitting there like a puppet. So I just thought to myself, no ways, not today, 'cause today you caught me on the wrong mood, really, I just thought, I can't just believe that she actually done it again. I use to think that she doesn't think before she says something, but then afterwards I thought, you are saying it just to make me feel shit because you think it gives you, all the status in the world because you are a grown woman, just because you have a child. But just remember that you were a child when you had that child."

Veon argues that infertile women should still be seen as true women because they are not childless by choice. Communities on the Cape Flats perceive infertile women as an unnatural occurrence, nature's freaks. Desiree also says that some people perceive an infertile woman as being less of a woman. She argues that giving birth to a child may prove that you are physically a woman, but it does not affect one's femininity. Roxanne agreed, saying she does not see why a woman cannot be seen as a true woman if she does not have children, because there are multiple aspects to womanhood. However, in the eyes of a woman's family and in-laws, only having a child bestows that status. Infertile women's inability to access the social status reserved for mothers creates ambiguity about their social place. In trying to understand infertile women's childlessness and their place in their communities, people on the Cape Flats seek the causes of infertility.



#### **6.4. PERCEIVED CAUSES OF INFERTILITY**

In Chapter Three, I argued that there is a lack of knowledge about the biology of reproduction among people on the Cape Flats. They do not necessarily seek answers to health problems in bio-medical terms. When a woman is infertile, people struggle to understand why this is so. Motherhood is seen as a normal occurrence because women are biologically designed to bear children. People do not readily accept bio-medical reasons as sufficient answers to their questions about infertility. Instead they seek answers in the cultural, spiritual and moral realm. I explore some these explanations below.

Many believe that infertility is caused by unsanctioned contraceptive use. The 'secret' use of contraceptives especially by teenage women to avoid conception is frowned upon. Various beliefs, rumours and fears surround contraceptive use, ranging from the idea that contraceptives cause infertility to contraceptive use signifying promiscuity. This is not restricted to the Cape Flats; Caldwell and Caldwell (1987) (cited in Mgalla and Boerma, 2005:194) state that, "Belief, rumors, and fears about the side-effects of modern contraceptives abound in Sub-Saharan Africa." Even the infertile women supported this belief.

Veon said that infertility could be caused by contraceptive use – more specifically, contraceptive use at a young age. She believes that using contraceptives as a teenager for her irregular periods could be the cause of her infertility. "I've heard, like, if you on birth control at a young age, you are more prone to growths and cysts and things like that. Even if you are on birth control, a Sister (nurse) once told me that people that are on birth control are more prone to develop breast lumps, and it can even turn to cancer and things like that. And that's why I thought that, and I still do think that

maybe it could be things like all the birth control that upset my hormonal balance and everything. Because, I mean, they changed me from one thing to another without giving it a period for it to work out or anything."

The focus group participants agreed. Contraceptive use was thought to be the main cause of infertility. They stated that infertility could be caused by a woman's use of contraceptives when she was a teenager. She would then have 'problems' with her womb. The contraceptive Pill and the contraceptive injection 'eat away' at a woman's womb. The belief that the use of contraceptives outside the sanctioned state of marriage leads to infertility reinforces the perception in these communities that contraceptives are sexually bad.

Immorality was identified as another cause. Veon said that when she was young there was a widespread belief that infertility is caused by immoral behaviour. A woman is expected to conceive soon after she is married. If she takes longer than expected, people speculate that she had illicit sex and an abortion as a teenager and is now being punished for it. The idea that a woman's infertility is due to sexually immoral behaviour is so powerful that it is more likely to be believed than a bio-medical explanation. The focus group participants also said that they personally believed that infertility is a result of sexual immorality. When asked if there is any truth to this claim, Sister October replied that, for various reasons, engaging in sexual intercourse at a young age could lead to infertility later in life, because of untreated sexually transmitted diseases. This belief was also observed by Roth Allen (2005) in an anthropological study on the cultural constructions of risk during childbirth in Bulangwa, West Tanzania, where infertility was seen by the locals as a consequence of immoral behaviour.

Divine will was also accepted as a cause of infertility. The focus group participants believed that if a woman is unable to have children, she should seek medical treatment. If this is not successful, she must accept the result because it is God's will. This belief is not only used to support the construction of infertility as a 'punishment'; it is also used by infertile women themselves to make sense of their condition. The belief that infertility is due to divine intervention is common on the Cape Flats. Religion becomes a source of comfort when answers cannot be found anywhere else. Desiree stated that her religious beliefs have given her the strength to deal with her problems. She believes that the Lord has a plan for her life and it is His will whether or not she will have children one day. Roxanne, too, has found comfort and strength in religion. She also believes that God's will controls whether she will have another child, because people told her that she would never have children but through prayer and belief she conceived. Angel and Veon also believe that if they have children, it is God's will in action.

The cultural constructions of infertility are supported by many religious doctrines, which state that women were placed on earth to bear children and that all women have a God-given maternal instinct. Inhorn (1996:76) states that infertile women are told that "infertility is a condition from God, which he bestows upon certain human beings for a reason." Thus, infertile women are not supposed to question their infertility because it occurs through divine intervention. Religious reasons for infertility do not take into account infertile women who know that their condition is due to human causes such as botched surgery by medical professionals, self-induced abortions, or traditional fertility treatments.

These reasons given for the causes of infertility only compound infertile women's unhappy experience of their infertility. The complexities of infertility not only have social and cultural repercussions, but hold personal implications for those who suffer from it.

One aspect of such suffering is emotional anguish. In Veon's journal entry for 12 July 2006 she states that:

"It's not easy being inside my body; I feel that I'm a reject of life. I keep on asking myself why? But no answers are flooding in. It makes it easier to have some possibilities of what might be wrong with me. The fact that there are treatments out there; I've not been diagnosed with anything. So that makes it just as hard. It's easy finding out but the doctors are so expensive. Carl wants me to skip our debt this week, so I could go for a Pap smear but that would or could be the wrong thing to do. Not going to the doctor but not paying our bedroom suite because it's behind 2 months already. What are we going to do? A baby is the most important thing I want and need in my life aside from the fact that I desperately need a job, what am I saying? I desperately need a job, but I want a baby so much it hurts and I can't make it better. I can't even help myself, getting myself the necessary medical help. What is wrong with me? Do I deserve this? Do I deserve to be a mother? How long will my husband put up with my imperfection? I'm so flawed. How could anyone love me this much? I cry and cry; weeping when he's not around because I can't and won't let him see how needy and weak I can be. For years I have prayed for a family. I don't want to be sad all the time but I can't help myself. I'm happy with my husband and he with me but a child would really be a blessing in our lives. I feel so afraid to walk into friends or even hear about family because everyone always expects babies to come with no

problems. Some say that I shouldn't be anxious but I don't know, if I am not thinking about it, that's impossible."

These women's emotional anguish is worsened by the stigmatisation which they suffer. In addition, they internalise the negativity associated with infertility as constructed by their communities, causing yet further anguish.

Some of the participants expressed feelings of loneliness. Veon and Angel experience immense loneliness. Veon knows there are other women dealing with infertility but she feels that she is alone in this situation because she is different to the rest of her family. The women also spoke of suffering in silence. Sarah uses her chirpy, bubbly personality to hide her true feelings. She refuses to speak to other people about her infertility. Similarly, Veon suffers in silence. The women spoke of feelings of isolation. Angel isolated herself from her support networks of friends and family because she fears their judgment. On occasion Veon has also isolated herself from these groups. She only does this when she is very depressed.

These women also expressed feelings of inadequacy. Similarly, Aquifa said she felt inadequate as a woman because she has never conceived. The participants must also deal with depression because of their infertility. Sarah lamented that there are times when she knows she is suppose to menstruate but she will hope that it would not happen and wishes she was pregnant. Menstruation, a sign that there is 'nothing there', depresses her. Desiree feels the same way at the same time of the month.

Angel also gets depressed about her infertility. She feels that her life is empty without a child. Veon gets depressed because she struggles to deal with the idea that she is not able to bear a child.

Some of the participants have experienced obsessive tendencies. Roxanne stated that while struggling to conceive her first child, she was obsessed with infertility. Veon still obsesses about her infertility. All the participants have asked themselves what they have done wrong to deserve their fate, or have questioned God's unfairness. Veon explicitly said that God is punishing her. She sometimes asks, "God, Why are you doing this to me? Are you punishing me for something?"

Some of the women said that they have come to accept their infertility. Sarah, Desiree and Angel feel that 'what must be must be' but with great difficulty. Veon still holds onto fragile hope that she may still bear children.

### ***Divorce and Failed Relationships***

In a patriarchal society like South Africa's, having children is very important to both men and women. Gijssels, Mgalla and Wambura (2005) state that when a marriage is consummated, it is expected that children will follow soon after. The desire to have children is very powerful for both men and women because masculinity and femininity both depend on proving fertility. Culturally, marriage is a licence to procreate, and when procreation fails to happen, it is seen as abnormal.

In contemporary South African society, couples who are in long-term relationships experience the same pressure to bear children. Sandelowski (1988) [cited in Dyer, Abrahams and Hoffman, 2002] states that in all societies there is normative pressure to bear children. While it may be involuntary, infertility remains a violation of the behavioural norm to reproduce. This results in infertile women being perceived as deviant. Furthermore, Dyer, Abrahams and Hoffman (2002:1661) state, "When the psychological and social implication of this deviant status are analyzed, women in the

developing world seem to carry additional negative experiences. Stigmatization, ostracism, marital instability and abuse are not unique findings but they appear to occur more often and with increased severity."

While childbearing is important to both men and women; the sad reality is that women bear the brunt of the stigma and suffering associated with infertility. They are the ones that are divorced or abused by their husbands, as we saw in the collapse of Veon's first marriage. She filed for divorce because she suffered physical and emotional abuse at the hands of her husband. He abused her because he blamed her for not giving him children. Veon firmly believes that men leave women who cannot bear children. The focus group participants supported this belief, relating stories of two infertile women who were divorced by their husbands, who then went on to have children with other women.

Relationships may fail due to female infertility. Angel has had three failed relationships which she blamed on her inability to conceive. She thinks her relationships would not have ended if she been able to conceive.

Yet, childbearing does not necessarily protect a married woman from the threat of divorce. Aquifa's father divorced the mother of his five children and moved in with an infertile woman. While women are blamed for infertility, men are often the source too. For example, Veon suffered physical and emotional abuse at the hands of her first husband because he blamed her for not being able to give him children. Yet, he was personally struggling with his own infertility and kept it a secret. Infertile women's partners play a big role in their experiences of infertility.

## **6.5 PARTNERS AS SUPPORT**

Partners often ameliorate women's suffering as they negotiate infertility. Some women do not deal with an inability to conceive in isolation. They experience the negative feelings of not conforming to the dominant ideology of motherhood while they are in marriages or relationships, as members of a family; and of communities. Out of all these, the union in which they exist is the most important. A partner not only provides physical support as the other member of the 'baby-making team' but his emotional support, or lack thereof, influences his infertile partner's treatment-seeking behaviour and affects how she copes with the emotional anguish she suffers.

All the participants supported the argument that if infertility was approached as a couple's problem rather than a woman's problem, it would help enormously. The following example illustrates how a partner's support influences an infertile woman's treatment-seeking behaviour and how she deals with her infertility.

During Roxanne's struggle to conceive her first child, her husband was very supportive. When she became despondent, she would say to him, "Don't you rather want to adopt?" and his response was always, "We will have a child." Her husband's feelings have an important influence on whether or not the couple will try for another child. Roxanne is prepared to undergo fertility treatment to conceive her second child but she feels that her husband is unwilling to do so. While he would be happy if they had another child, she does not think that he has the emotional and physical stamina to go through that ordeal again. Roxanne would, but is hesitant because she is unsure whether she will receive the same amount of support from her husband as she did the first time. When asked what she would do if her husband was willing to support her again, she replied that she would not hesitate, and would start treatment immediately.



### ***Invisibility of male infertility***

In these communities, infertility is socially defined as a woman's problem only. Patriarchal values exclude men from blame when a couple is unable to conceive. However, according to the bio-medical definition of infertility, both partners have to have a medical examination before the source of infertility can be identified. Yet, the female partner is most often seen as being the cause of infertility. Though these medical guidelines are in place, men are rarely perceived to be at fault, and in most cases women are the ones who seek treatment. Even Sister October states that male infertility is not a real problem on the Cape Flats – because she has not received a lot of feedback from women coming back to the clinic to report that the problem could possibly lay with their partners. Male infertility is a well-hidden problem. If we ignore it, the stereotype of the woman being at fault is perpetuated and male infertility continues to be invisible. The following example shows that male infertility is of concern for couples that are unable to conceive.

Veon has dealt with male infertility in both her marriages. During her first marriage, when she did not conceive, her husband taunted her. He hurled insults at her while he was physically abusing her. Veon carried the blame for years. Two years ago, her first husband's mother told Veon that her ex-husband is infertile. She said that he was born that way, and his parents have always known that he will never be able to father a child. Veon was shocked by this information, and she believes that if she had conceived during her first marriage, her husband would have killed her because that would have been proof that she had cheated on him.

Veon's second husband feared that he might be infertile. As a teenager, he had an STD and he did not seek treatment for it. After they were married, he consulted with a

nurse at his workplace who advised him have his sperm analysed, as he was very worried that he might be the cause of the couple's infertility. The sperm analysis showed that he has a healthy sperm count.

## **Conclusion**

In this chapter, I explored the impact of social stigma on the lives of infertile women on the Cape Flats. I showed that it holds severe negative consequences for these women. Being infertile in a society that valorises motherhood is a real burden.

Women who are perceived to be infertile are stigmatised, abused and suffer from psychological distress. This was illustrated by the life history of Veon, who suffered physical and emotional abuse in her marriage because she could not bear children. This is by no means uncommon. Veon's story also illustrates how infertility is often socially constructed as a woman's problem without any investigation of which partner is indeed the cause.

Infertility is stigmatised in the communities on the Cape Flats. This stigma is perpetuated through various social practices that serve to exclude the infertile. This treatment also contributes to the construction of infertile women as the deviant 'other' in opposition to motherhood. Infertility is considered to be a threat to the social norm that upholds motherhood as mandatory for all women. Motherhood is the means by which women on the Cape Flats access social power and status. Infertile women cannot achieve such power and status. They are subjected to gossip which is used to police women's behaviour and also to construct the stereotypical image of the infertile woman. The deviant status of infertile women is also constructed through the use of certain derogatory terms, which demonstrate the contempt with which these women are treated. It seems that their childlessness justifies their bad treatment, especially at

the hands of women who have proven their fertility. The threat of gossip and the consequent social judgment of the community, including close relatives, friends and neighbours, have caused infertility to become invisible.

Infertile women's inability to access the social status reserved for mothers causes confusion as to where they fit into society. In trying to make sense of this situation, people on the Cape Flats attempt to explain what causes infertility. These explanations include speculation about immoral behaviour, unsanctioned use of contraceptives and divine intervention. However, it is interesting to note that the first two of these can be seen as the woman's own fault. Immoral behaviour and the unsanctioned use of contraceptives are against the proper social and cultural behavioural expectations of young women in the communities of the Cape Flats. Thus, as infertility itself challenges the status quo of motherhood, so too do the assumed causes.

Veon's life story showed not only the social stigmatisation she experienced, but also the emotional anguish she suffered. For the eight years she has been trying to conceive, while being subjected to gossip and stigma. This has caused her to internalise the negativity that her community directs at infertile women. The other participants, and by inference most infertile women, have suffered similar fates. They reported feeling lonely, suffering in silence, feeling isolated, inadequate and depressed, being obsessed with childbearing, and feeling as though they are being punished by God. The emotional anguish is increased by the fear of divorce and failed relationships. I have shown that while a couple's infertility is not the sole reason for divorce or relationship failure, it has a great impact on it.

For the lucky few, the stigmatisation and anguish experienced does not occur in isolation; and this chapter also addressed the role of partners as support in dealing with infertility. I demonstrated how a partner's support influences an infertile woman's treatment-seeking behaviour. When a partner is supportive, a woman is more likely to seek treatment. Infertility is then approached as a couple's problem rather than perpetuating the social belief that it is a woman's problem.

The influence of partners was also explored in the section on male infertility. While I intended that this study should focus on women's experiences of infertility, the impact that male infertility has on how a couple approaches a couple's infertility is important. It illustrates that while women are more willing to seek treatment, they are aware that the possibility that their partner is infertile is a real threat to conceiving. However, these women also accept the social belief that the problem lies with them, as most often their partners only seek treatment after the women themselves have started the process.

everything in my mind. Carl is at work and I can't wait to see him to give him the news. I dream about how it could feel when the baby moves inside me for the first time. How everyone I get along the way, who always asked, 'When are you planning on having a baby?' would compliment me and most of all, my ex-husband, the man who made me feel less than a woman, would see my belly grow and that he would remember and be so ashamed of all that he said and did to me and I would walk with my husband, looking great and glowing with pride. Well, at least that is possible in my dreams."

Aquifa and Veon's experiences illustrate that motherhood is very important to infertile women. In the next section I explore the diverse meanings that motherhood holds for these women.

## **7.2 MEANINGS OF MOTHERHOOD**

Infertile women re-negotiate the meanings attached to motherhood because they are unable to conform to the dominant norm. These new meanings are not those one would normally associate with working-class motherhood on the Cape Flats. Different women have different experiences and expectations of motherhood, and similarly, the women who participated in this study have their own ideas of what motherhood means.

Veon feels that becoming a mother would make her feel complete. She would be fulfilling one of the purposes for which she was created – because she says women are created to bear children. Motherhood would fulfil the maternal instinct that she has felt for most of her life. It means everything to her. Angel and Desiree expressed the same sentiments. They stated that motherhood means loving, protecting and caring for

## **CHAPTER 7: "DJY'S EITHER 'N MA OF NIKS" - WHAT IT MEANS TO BE A MOTHER IN THE COMMUNITIES OF THE CAPE FLATS**

Motherhood as a social and cultural construction is a very powerful ideology in South Africa, and specifically on the Cape Flats. Motherhood is the key identity to which all women should aspire. There is a very strong cultural expectation that all women will become mothers. It is expected that one must be a mother because it illustrates the social and cultural pathways of becoming an adult, feminine person. Biological motherhood is important, because it bestows status and authority upon women which are not accessible through other means. Consequently, women of childbearing age experience both conscious and unconscious pressure to conform to the dominant ideology of motherhood. They are aware of the resultant stigma when one deviates from this norm. However, it is not enough to become a biological mother – women must aspire to be good, respectable mothers.

I argue that infertile women feel the pervasiveness of this pressure to the greatest extent. They are aware of the social and cultural meanings attached to motherhood in their communities, but they are unable to access this identity. Because of their infertility, they have no place in the social structure of their communities. They therefore idolise not only motherhood, but also good motherhood. Their struggle to conceive informs their strong opinion of motherhood, even to the extent that they castigate women who deviate from social and cultural prescriptions of good motherhood, such as themselves.

one's child to the best of one's ability, and to sacrifice the self for the benefit of one's children.

These women view motherhood as a natural extension of their own being. They all said that being a mother comes naturally. Similarly, Inhorn (1996) observes that in Egypt, women are seen as 'naturally' performing the roles of childbearing and motherhood, due to their God-given 'maternal instinct', a primordial drive fuelling women's motherhood desires and their capacity to care for their children with affection. Women are thought to be born with this instinct so that it remains with them for the rest of their lives. This is why little girls play with dolls, why old women delight in their grandchildren and why women who marry hope to have children immediately. Motherhood allows women to replicate the care, affection and compassion of their own mothers and to complete what the poorest women see as their primary 'mission' in life. For them, children take precedence over everything else - over husbands, their relatives and jobs.

The infertile women in this study hold an idealistic notion of the meanings of motherhood. They all said that motherhood is a positive experience that focuses on loving, nurturing and rearing a child to the best of one's abilities. Other mothers however, indicate that this is not always the reality. To illustrate how perception and reality can differ, a focus group was conducted with four mothers from Tafelsig, Mitchell's Plain.

Anne is a 59-year-old, Afrikaans-speaking, unemployed, coloured woman with a grade six education. She is a widow. Anne has eight children, twelve grandchildren and one great-grandchild.

Eileen is a 53-year-old, English-speaking, unemployed, coloured woman with a grade seven education. She is a widow. Eileen has six children and eight grandchildren.

Snoopy is a 32-year-old, English-speaking, unemployed, coloured woman with a grade nine education. She is a widow. Snoopy is mother to four children, and is Eileen's eldest daughter.

Meagan is a 23-year-old, Afrikaans-speaking, unemployed coloured woman with a grade seven education. She has been with her partner for eight years and is engaged to be married. She is mother to two daughters.

All the focus group participants agreed that the meaning of motherhood has changed over time. During infancy and early childhood, the joys of motherhood overshadowed all the problems associated with childrearing. Anne states that as children grow older, the problems increase. She said that if your children are young, motherhood is a joy, but after puberty, a mother has to be strong to face the ensuing problems of childrearing, especially when there is no father figure in the home. Snoopy says she too struggles with her older children. She found the little ones more manageable because, a hug and a cuddle can solve problems. The older ones however tell her, "You're stupid. We are big, why do you want to kiss us? Why do you want to hold us?" The participants agreed that these changes in affection are not good. They say mothers are rearing a new generation who rejects discipline and who say that – "You don't tell me what to do."

All the women agreed that motherhood means having 'hair on your teeth' (patience and resilience). For Snoopy this means reprimanding her children all day and doing



everything herself. She is a widow and a single parent. Her children constantly challenge her authority. Similarly, Anne stated that her children and grandchildren too question her authority. Previously, her children obeyed her; but now, she says they claim that she is 'old-fashioned'. She says that she loves children but rearing them is becoming increasingly difficult.

All the focus group participants agreed that a mother must be a disciplinarian. They argued that discipline is the most important aspect of motherhood and childrearing, even more so when the father is absent. Discipline, they say, influences children's behaviour in the community and serves as the means by which a woman's mothering skills are judged. Anne says that when a child misbehaves, people are very quick to judge the mother, but people don't know what a struggle it is to discipline children. Mothers cannot control what the child does outside the home. This illustrates that a mother's respectability is not only dependent on how she portrays herself, but is also judged by her children's behaviour. Mothering is seen as an extension of the feminine self. If a child acts inappropriately, it brings the mother's respectability and morality into question.

Snoopy argued that she and her mother have different mothering skills and styles. Snoopy's mother, Eileen, agreed. Eileen was very easy with her children, while her daughter is a very strict disciplinarian. Snoopy says that is so because she is single parent and so finds parenting more difficult. Meagan and Anne also stated that they were not like their mothers. Thus, while motherhood remains an important cultural and social construction, the experiences of mothering are not constant over time.

My informants also distinguished between 'good mothers' and 'bad mothers.'

### **7.2.1 Good mothers**

It is not enough to demonstrate motherhood through childbirth. 'All women on the Cape Flats, fertile or not, aspire to being good mothers. Good motherhood enables women to access supportive networks and to gain status and authority within their communities. Drawing on Salo (2004), I distinguish between good or respectable motherhood, and bad motherhood. The women on the Cape Flats are culturally categorised into those who conform to the ideal of good mothers, and those that don't; or bad mothers.

The in-depth interviews stated that a good mother puts the needs of her child above everything else, including her own needs and feelings. A good mother ensures that her child is fed and clothed, and looks after every other aspect of the child's life. She is also a disciplinarian, but provides unconditional love and emotional support.

The focus group participants argued that all mothers try their utmost to be good mothers. They thought that it was difficult to define exactly the discreet characteristics of good motherhood. However, they tried their utmost to be the best mothers they could be. They said that they found their offspring's' critiques of their parenting styles to be most hurtful. Their children used these criticisms to hurt and challenge their authority as mothers.

It is interesting to note that while the participants' perceptions of good motherhood focus strongly on their emotional capabilities to nurture; they said that their community idea of good motherhood focuses more on the mother's ability to provide material security.

Desiree and Angel stated that community standards describe a good mother as a mother who looks after her children. A good mother ensures that the child is clean, fed, lives in a safe and comfortable environment and goes to school. Veon argues that it is very difficult to be a good mother in contemporary South African society, particularly on the Cape Flats. She feels that there are no examples of good mothers in her community.

According to Snoopy, a community considers a mother to be good, if she takes good care of her children and they wear clean clothes every day. Ironically in Tafelsig, mothers are unable to maintain such cleanliness all day long. Snoopy stated that if she ensured that her children remain clean all day, she would have to do laundry constantly. Good motherhood is dependent on the children portrayal of their mother's domestic abilities. The women here acknowledged that they are unable to adhere to the high standards of motherhood they set themselves.

All the women agreed that *ordentlikheid* (respectability) is an important characteristic of good motherhood. Desiree argued that respectability is important because being a mother is about setting an example for your children. If a mother is disrespectful, her child will follow her example. Similarly, Angel states that respectability is important because children look to their mothers for guidance on appropriate behaviour. Veon shared this sentiment. Roxanne pointed out that respectability is not only important to good motherhood, but to life in general.

Elaine Salo (2004) is one of the few researchers to have explored cultural constructions of motherhood on the Cape Flats, in the context of the marginalised Coloured community of Manenberg. Cultural constructions of motherhood are

defined as follows: "Notions of motherhood and mothering are culturally constructed. Not only do they take their meaning from within specific cultural milieus depending upon such factors as class position, rural versus urban residency, degree of religiosity, and fertile versus infertile status. Furthermore, the meaning of motherhood may shift over time in response to such culturally metamorphosing events as political revolutions, mass migrations, and religious revivals." (Inhorn, 1996:84). Salo's exploration of the meanings of motherhood is important to this study, enabling us to view the different social life stages through which women progress in their lives. Through it I show how the participants in this study conformed to or deviated from the prescribed cultural constructions for women on the Cape Flats.

Salo (2004:165) states that during every life phase there are certain gendered prescriptions or expectations set for women. The cultural and social expectations are necessary to ensure the continuance of what is acceptable female behaviour in working-class communities. Salo (2004) argues that in working-class communities, motherhood is synonymous with respectability. The phase that precedes being a respectable mother is being the 'good daughter'. Good daughters go through a rite of passage which transforms them from the lower status of the good daughter to the more powerful role of the respectable mother. Salo (2004:162) states, "A young woman's first steps to becoming *moeder* (mother) are marked by her initiation into adulthood through pregnancy. Most women express the desire that their daughters should first have a *skoon troue* (clean marriage) before they bear children, in keeping with Christian and Islamic mores. Mothers take great pride in their daughters who remain chaste, because they embody their own successful careers as respectable parents."

As mentioned in Chapter Six, Roxanne, Desiree, Veon, Aquifa and Sarah progressed from being good daughters in their parental home to adults through clean marriages. While Roxanne and Veon were the only two virginal brides, all these women entered into marriage without any children. A *skoon troue* is a legitimate, socially acceptable way of introducing a young woman into motherhood, while at the same time affirming her mother's respectability. However, most working-class households do not have the necessary financial resources to fund a clean marriage. Because young women desire a more senior social status than that of the dependent child within their parental household, most have a child before the *skoon troue* can occur.

It is important to note that in this context, teenage pregnancy is not the negative experience constructed by middle-class ideology. While having a child outside marriage remains problematic in most societies, within working-class communities there are certain honour codes which assist with the legitimising of illegitimate pregnancies. The participants in this study were not able to take advantage of these codes and enter respectable motherhood at an earlier phase in their lives. They have been unable to conceive since becoming sexually active. However, their decision to wait until marriage to become mothers was also influenced by their mothers, who warned them about not disgracing their households by bearing children before they were married.

Furthermore, Salo (2004:187) states, "women begin their moral careers as *ordentlike moeders* (respectable mothers) when they bear children after a *skoon troue* or clean marriage, or more commonly, when partners claim responsibility for their pregnancy. A woman's ability to control her own as well as her daughter's sexuality is the constitutive sign of respectability. Control over sexuality is marked through a number

of practices. One of these is marriage. The *ordentlike* woman's sexuality can only find expression in the confines of the monogamous marriage. An *ordentlike* mother would not allow her daughter to be sexually active, use birth control methods, or become pregnant out of wedlock." The control of the participants' sexuality was illustrated in Chapter Three. It was shown how their mothers protected their own as well as their daughters' respectability by only providing sexual education which conformed to the cultural prescriptions of their context.

### **7.2.2 Bad mothers**

The following section explores what it means to be a bad mother, according to the women interviewed for this study. First I examine their personal views on bad mothers, then their opinions of what their communities consider to be bad motherhood.

Roxanne would view a mother as bad mother if she didn't ensure that her children were physically clean, fed and didn't spend time with them. Desiree said that a bad mother is a mother who only cares for her child's physical needs but neglected its emotional needs. Similarly, Angel said that bad mothers do not provide their children with emotional and moral guidance. People in the community only use external indicators to determine bad motherhood, for example, if a child is dirty and untidy.

The participants stated that another indicator of bad motherhood is indulging children's material desires by buying designer clothing. Desiree argues that this teaches children to be materialistic. She says that mothers use their children as economic trophies, to indicate that they have the financial means to dress them in expensive wear. Roxanne echoed this sentiment. Angel, too, said that buying brand

names items inculcated 'wrong values'. She said that mothers who do this do not consider how they will provide adequate financial support for their children in the long-term. Brand-name clothing teaches the child their worth can only be measured in material goods. In addition, parents, and more specifically mothers, do not necessarily have the money to afford these clothes and often buy them on credit. This teaches the child that it is acceptable to live beyond one's financial means.

Bad mothers were also considered to be those women who set poor example to their offspring. Veon considers all the mothers in her street as examples of bad mothers. They don't take care of their children; they are often unaware of their children's activities, they use foul language, and they drink and use drugs in their children's presence. These children are disrespectful to their mothers because that is the behaviour they observe in the home. Similarly, the focus group participants perceive bad mothers to be mothers who drink all day, use drugs during pregnancy and while their children are still young and they don't care about their children's well-being.

Angel spoke about one of her neighbours whom she considers to be a bad mother. This woman has a child and is currently pregnant. She drinks continuously despite her pregnancy. She was often in physical fights and undressed in public while fighting. This women's behaviour has negatively influenced her four-year-old son's behaviour. In addition, she did not pay their municipal bills. Municipal workers have disconnected their water supply. *"Die aand toe sê sy die man moet daar gaan pieter, by die boks, daar waar die water, by die drain want die kaffirs will nie betaal nie, hoekom moet sy betaal. Nou dit is mos, kyk, kyk djy leer daai kind dieselfde dinge wat djy in jou het en die kind het dit repeat vir 'n groot vrou. 'Oh, ons water is aan want my ma het gesê my pa moet die water gaan aan sit want die kaffirs will nie betaal nie,*

*nou hoekom moet sy betaal. Hoekom moet ons water betaal; die kaffirs will nie water betaal nie.*" (That evening, the wife told her husband to fiddle with the connection box because the *kaffirs* don't want to pay for their water, so why must she pay. Now it's like this, you teach that child to be the same like you, and her child repeated what his mother said to an older woman: 'Our water is on because my mother told my father to switch it back on because the *kaffirs* don't want to pay, so why should she pay. Why must we pay for our water, the *kaffirs* don't want to pay for their water?')

Veon, too, observed that bad mothers perpetuate the legacy of racial discrimination. One afternoon, she heard a commotion outside her house and went to investigate. She saw her neighbour's seven-year-old son and his six-year-old brother threaten a little black girl who was walking home from school. She said "And I couldn't get to the door fast enough but saw them kicking this child and she was coming from school, and her, she had her shoes, she had her shoes in her hand and she was walking, bare feet. You know on the pavement on her way home. And then this one child actually called her a *kaffir*, 'Djy jou kaffir kom hier' (You *kaffir* come here) and he spat in her face. And I felt so BAD for being Coloured, for being, like, part of this community because he spat in her face. And she started crying, as she wiped it off, she started crying and I mean I couldn't even get to the door that fast and his mother was sitting right there. And I looked at him and I thought, God why do you create... evil like this. Why would this kid, why were they born? And they are just corrupt. They have no respect for no-one and, I mean, it will stick in that child's mind forever, that won't ever go away because she'll always remember, 'I was little, and they spat in my face and they called me a *kaffir*'. Okay, the word, but I mean, they spat in her face and she cried and she just walked. I couldn't get to the door fast enough."



Salo (2004) states that the cultural construction of the *sleg* (bad) mother exists in contrast to the construction of the respectable mother. says, "While bearing a child is regarded as one of the central features of the *ordentlike moeder*, one does not automatically become *ordentlik* upon giving birth. A mother's *ordentlikheid* is ascertained through marriage or, most often, when her partner acknowledges paternity of the child. *Ordentlike* mothers who do not vigilantly police their personal moral careers could also retrogress and become *sleg*. Women claim that their sisters who have become morally degenerate are individuals "*wie nie mooi na ha' self kyk nie*" (who have not looked after themselves). '*Sleg*' is the umbrella term used to describe an array of behaviours, attitudes and dress codes and, more importantly, a pattern of economic expenditure that the respectable women associate with moral degeneration. To call a woman *sleg* is to confirm not only her sexual, moral and economic dissipation for selfish gain, but also to forecast the impending economic and social alienation of her household from the community. *Slegte* women are perceived primarily as women who don't care about the physical and moral well-being of their household members." (Salo 2004:190)

The participants' description of bad motherhood resonates with Salo's definition. A bad mother does not take care of the moral, material and emotional needs of the members of her household.

Respectable mothers can regress into bad mothers. These women strive not only to be mothers, but respectable mothers.

The regression of respectable motherhood can also be illustrated in Snoopy's case. She was first perceived as a respectable mother. However, after she was widowed, her mother complained that her daughter always shouted at her own children and her children did not listen to their mother. Snoopy also said that she knows that people consider her to be a bad mother because her children are always 'dirty'. After her husband died, she felt overwhelmed by responsibilities. Snoopy became economically and socially alienated from her community. She was evicted from her home that her husband bequeathed her because she could not afford the bond payments. She is currently renting a room from a family member after drifting from home to home.

### **7.3 BIOLOGICAL MOTHERHOOD**

I have established that motherhood bears significant cultural status on the Cape Flats. The role of mother has significance for women because it affects how they are perceived in their communities. Biological motherhood provides various social rewards to women that cannot be attained in any other way. In these working-class communities, women are socialised to aspire to be mother. Yet, the social and cultural indoctrination that a young woman receives does not wane when she is unable to conceive. Faced with the powerful expectations that they must become mothers, some infertile women opt to adopt children to fulfil expectations. In these communities adoption, though presented as an option for infertile women, does not carry the same value and status as biological childbirth. Giving birth to biological children remains the ideal.

The participants in the focus group supported the notion that child-bearing is important on the Cape Flats. Eileen stated that it is important to conceive because it

sets an example to other women. Her daughter, Snoopy, states that if you don't bear children, you're not important in the community because you are not a mother. It is not just motherhood that grants a woman status, but more specifically biological motherhood. These mothers supported the argument that it is important to give birth to your own children, "because if you adopt somebody else's child, they are going to look for their mother." It is important to have your own children and bond with your baby during pregnancy and breastfeeding.

When we considered adoption as an option for infertile woman in Chapter Five, we saw that though it fulfils the need for a child, it does not confer the same status as biological childbirth. The focus group participants agreed that women who adopt children do not have the same status as 'real mothers' because they are not rearing their own children. They don't really know what it means to be a mother, because they have not experienced carrying a pregnancy to full term, or the pain of childbirth. The following section will look at whether or not it is important to give birth to one's own children, and why it is important.

Veon feels that it is important to give birth to her own children. Here she substantiates her claim: "Because then you feel like you've gone through all this and you can relate to every other women, like in the Beginning when Eve had her first baby. You can relate to that because you were born out of her, so each generation is born out of a mother, and I mean even if you adopt a child, that child was born out of a mother but like the Lord said, 'Blessed be the child that is born from the womb.'"

Having her own children is important to Angel and Desiree too. Desiree will not consider adoption firstly because it poses a bureaucratic nightmare, and secondly because there would be the possibility that the biological mother would want to

contact her child, or that the child might later reject its adoptive parents. Roxanne also feels that it is important to give birth to your own children because they would inherit your own genes.

## **Conclusion**

Motherhood is a powerful social and cultural construct on the Cape Flats. There is an unspoken expectation that all women should aspire to become mothers, to attain the social status and power that accompanies this identity. A woman on the Cape Flats can only be seen as a whole person when she becomes a mother and bears a child. For infertile women in these communities, the power of the motherhood mandate is pervasive. Their communities expect women to become mothers, yet they are unable to do so. This was demonstrated by Aquifa's story, which illustrated the social pressure that women experience to bear children and be initiated into the social circle of mothers. This pressure increases as women go through the life cycle. The pressure that is exerted over infertile women comes from partners, peers, family, and community members. They are acutely aware of how their inability to conceive leads to them being viewed as lesser persons.

The social and cultural meanings attached to motherhood that exist in the communities of the Cape Flats influence the meanings of motherhood taken on by infertile women, but also by mothers themselves, making the ideology a lived reality. Infertile women's inability to conceive and the pressure that they experience on a daily basis to become pregnant, have caused these women to create an idealised image of motherhood. For them motherhood is filling a void, enabling them to live out the maternal instinct that they have experienced with other women's children. Some of the

participants stated that motherhood means everything. This construction of motherhood as a positive experience was challenged by the focus group members. They stated that women who do not have children assume that motherhood is a wonderful, fulfilling experience but in reality, having children in contemporary society can be a real burden.

However, it is not only motherhood but respectable motherhood that is idealised. Infertile women do not simply want to be mothers; they want to be good mothers, because being a good mother is the model that every woman strives to follow. There was a discrepancy between the perceptions of good motherhood held by the infertile participants, which centred mainly on emotional nurturance, and those held by the mothers in the focus group, who said there is no defining characteristic of good motherhood. Both groups' opinions of what the community determines to be good motherhood focused on the mother's physical capabilities.

The cultural and social circumstances that inform the construction of motherhood on the Cape Flats influence the definition of bad motherhood as well. It seems that this classification refers to mothers' morally degenerate behaviour which results in the physical, emotional and moral neglect of their offspring.

Biological motherhood still reigns supreme and was seen as preferable by all the participants. Adoptive motherhood, seen as an option for infertile women, is in reality not an option, because it does not confer the same social status as biological motherhood.

## **CHAPTER 8: CONCLUSION**

Feminists have argued against the power of motherhood as a dominant ideology and the primary aspect of women's identity. Firestone (1979) and De Beauvoir (1972) have argued for women to be allowed to make informed choices about becoming mothers. These arguments very often fail to acknowledge the social and cultural meanings that are attached to motherhood in working-class communities such as the Cape Flats. The motherhood debate seems to lose importance in a context where motherhood as an identity is revered above all else. Few accounts acknowledge what motherhood means to infertile South African women and, more specifically, to infertile women living on the Cape Flats. This study attempts to address this shortcoming by examining how women deal with infertility in a context that valorises motherhood.

Six women who self-identify as infertile were interviewed over a seven month period. A focus group discussion was held with four mothers to examine lived experiences of motherhood. Finally, three specialist healthcare workers were interviewed about infertility treatment.

Motherhood is a very important identity for women on the Cape Flats because it serves as the cultural and social pathway to adult feminine persons in the community. Motherhood bestows powerful social rewards upon women. (Woollett, 1991; Phoenix and Woollett, 1991). Inhorn (1996) states the inability of infertile women to conform to motherhood threatens their very identity, because they are defined as lacking a fundamental characteristic, motherhood which defines them as adult women. In many African cultural contexts such as ours, motherhood 'completes' a woman on multiple

meaningful levels – as a whole human being with a rounded social identity and an authentic woman who has assumed the normal rights, duties, and responsibilities of married womanhood (Inhorn, 1996). The achievement of motherhood demonstrates both individual and social growth and maturation. In these cultural contexts, infertility and the inability to conform to the dominant ideology of motherhood is perceived as a social crisis. Infertile women cannot achieve true womanhood; gendered and sexual identity is questioned and her sense of self is set adrift. She is perceived as not being able to achieve full adult maturity.

Infertile women's awareness of the powerful social meanings attached to motherhood has led them to construct an ideal notion of motherhood. Most often within this ideal, motherhood is considered to be completely fulfilling, positive and where perfect parenting comes naturally. Their ideas about motherhood focus solely on the emotional aspects of motherhood. They do not consider that motherhood could be a negative experience. Similarly, Inhorn indicates in Egyptian society, motherhood is perceived to be a positive experience by infertile women. In Egypt and on the Cape Flats, women believe that we all have inherent maternal instincts. All women will be good mothers and all women will become complete through motherhood. A woman loves a child more than any man will ever be able to understand. While a man is able to work away from the children and spend as little time as possible with the children, a mother is unable to do so because her life revolves around her children. This idealised idea of motherhood was challenged by mothers in this study who argued that their lived experiences of motherhood are incompatible with reality.

However, it is not only motherhood which is important on the Cape Flats. Being a good mother is the ideal which all women ultimately strive to attain. Thus, infertile

women not only yearn to be mothers but to be good mothers. Good motherhood, in which women conceive only in marriage and sacrifice all in interest of their children, is revered and gives a woman additional status amongst other women. Infertile women's inability to conceive leads them to hold strong opinions on the appropriate social and cultural meanings of motherhood. Infertile women and mothers alike have the opinion that certain women such as lesbian mothers and adoptive mothers do not conform to the idealised construction of motherhood that exists in their communities. Their perceptions dictate that women as mothers cannot and should not deviate from the cultural prescriptions of good, respectable motherhood.

In the context of the Cape Flats, biological motherhood is the only appropriate motherhood. This negates adoption as an option when a couple is unable to reproduce biologically. Prescribing adoption as a solution to infertility fails to account for the cultural meanings that are attached to childbearing and childrearing. Almost all the participants objected to adoption as a solution for their childlessness. Biological motherhood is what they strive for. The naturalisation and normalisation of motherhood on the Cape Flats has reinforced the belief that all women are naturally fertile and able to reproduce biologically. This belief leads to the invisibility of infertile women in this context.

Infertile women's inability to reproduce biologically has both personal and communal implications given the social and cultural meanings attached to motherhood in these communities. Infertile women suffer enormous emotional anguish because of their involuntary childlessness. The psychological consequences of infertility are a huge burden. These women experience depression and feelings of inadequacy and loneliness. They also have to deal with their infertility being seen as their own fault



and are often abused by husbands because they are unable to conform to the dominant ideology of motherhood. These findings are supported by Inhorn (1996:64), who states that "infertile women are seen by others, and often see themselves, as particularly pitiable and downtrodden. Not only do infertile women face an array of emotionally distressing experiences in their personal lives and as patients, but by virtue of their childlessness, they are seen as unable to achieve emotional fulfilment and may, in fact, experience identity crises of major proportions." Dyer et al (Human Reproduction, 2002) also conclude that infertile women suffer emotional anguish due to their infertility.

This anguish is not experienced in isolation, because the quest for conception involves the male partner as well. Infertile women's partners play a large role in how the women deal with their emotional anguish, and they influence the women's treatment-seeking behaviour. The participants stated that when infertility is treated as a couple's problem rather than a woman's problem, it has a positive effect on how a woman deals with it. In contrast, lack of support often causes infertile women not to seek treatment and also compounds their emotional anguish. In one case documented in this study, the physical and emotional abuse suffered by a woman because of her infertility caused severe emotional trauma. Lack of support also leads to divorce or failed relationships, though it is usually a contributing factor rather than the sole cause. These findings are in keeping with the finding of Dyer et al (2002). They state that their study on thirty infertile women showed that infertility has serious social consequences for its victims. Some women in their study were exposed to abuse, stigmatisation and marital instability.

The emotional pain that these women experience is a result of not only their own feelings about maternal inadequacy, but also due to internalisation of the stigma associated with infertility. This stigmatisation, often perpetuated through the use of derogatory terminology to speak about infertile women and through gossip, results in exclusion. Stigma negates the personhood of infertile women.

Infertile women in this study say they feel that mothers in particular socially exclude them. All participants agreed that because infertility carries a stigma, infertile women fear that their status will become publicly known. When a woman is married or in a long-term relationship and does not conceive individuals think that there is 'something wrong with her'. Infertility is commonly constructed as a woman's problem; consequently the female partner bears the brunt of social stigmatisation when a couple is unable to reproduce. Patriarchal ideology protects men from the threat of being labelled as infertile. As the participants' stories illustrated, male infertility is considered to be a remote possibility. In most cases men are asked to seek treatment as the last resort.

Infertile women's inability to fulfil the dominant ideology of motherhood means that they do not have access to the same social rewards and status as mothers. Within their families and communities, they are perceived to be without social status and power. They are often subjected to public humiliations such as persistent inquiries and ridicule about their failure to conceive.

Educated, middle-class South Africans commonly understand infertility in biomedical terms only. The working-class participants challenged this perception by self-identifying as infertile even though a few had not been medically diagnosed. This illustrates that on the Cape Flats infertility can also be defined culturally. Cultural

meanings are very pervasive in this context. The cultural prescription of motherhood on the Cape Flats are often far more influential in these women's lives. They are culturally defined as being unable to fulfil their primary duty as women, and are therefore seen to be incomplete. The participants' profiles in this study illustrate how cultural prescriptions about appropriate roles for women influence the realisation and diagnosis of infertility.

The women's realisation of infertility occurs processually. Some participants' realisation of infertility only manifested when they were married, but they were all adolescents when their reproductive problems surfaced. Their inability to conceive may be due to lack of knowledge and treatment options; but this is exacerbated by the widespread assumption that young women should, firstly, not have reproductive problems, but more significantly should not attempt to become parents. An understanding of the social and cultural desire for motherhood could lead to the creation of culturally sensitive infertility treatment. This same recommendation is made by Dyer et al (Human Reproduction, 2002:1667). They state that insight into infertile women's experiences can "contribute to the delivery of a culturally sensitive healthcare, e.g. by understanding that some women cannot get married without demonstrating fertility, while others may consider infertility a punishment for premarital sex."

The problem is compounded when open discussion about sex and related issues are taboo. Young men and women are only educated about appropriate sexual behaviour, and there is total ignorance of biological information that could assist women in understanding the workings of their bodies. Consequently women, and specifically infertile women, are unable to recognise the early signs of reproductive problems. I

found that the majority of the participants lacked basic biological information about female reproduction, which often prevented them from seeking medical assistance. Thus, although the biological indicators that point to the possible cause of a woman's infertility may be present, lack of education prevents the women from identifying the cause of their infertility.

Infertile women in South Africa should be better educated about the medical treatment options that are available. This should ideally occur in a safe, supportive environment where women are comfortable discussing their infertility openly. In support, Dyer, Abrahams and Hoffman (2002:1661) state, "Information is essential, as it is the basis for treatment as well as for prevention. Such information has to be delivered in a sensitive way."

Information is, however, not the only obstacle to infertility treatment. Another obstacle is their financial inability to access medical treatment and widely held prejudices against the public health sector. The participants perceived that the private health care sector in South Africa provides the best infertility treatment. Their opinion relates directly to the high costs paid for treatment. However, most infertile women cannot afford private sector prices. Some of the participants did see the private sector as the starting point for treatment, but were unable to continue because of cost. Often the best infertility treatment is available in the public health sector but infertile women view these public health services with disdain. They say that it does not provide adequate treatment and is inferior to the private sector. This is not necessarily due to groundless prejudice against the public sector, but because this service is genuinely overburdened.

The Infertility Clinic at Groote Schuur Hospital is the only facility in the Cape Town metropolitan area that provides services to infertile women on the Cape Flats. Once again infertile women may be prevented access because even at this facility there is cost involved, which is often insurmountable for working-class women. Infertile women's access was also hampered by this facility being overburdened and under-resourced. Consequently, not all infertile women are eligible for infertility treatment as there are criteria that they have to comply with, and numbers are limited. The participants also argued that their access to infertility treatment in the public health sector is limited by the moral beliefs of the health professionals involved regarding who deserves treatment. Dyer et al (Human Reproduction, 2002) state that the situation is changing. There has been an increasing awareness of the impact of infertility on reproductive health in the developing world, and recommendations that despite their lack of resources, developing countries should create effective infertility care policies. I fully support these recommendations, as effective infertility care is vital for infertile women in South Africa.

Because infertility is primarily seen to be a bio-medical problem one expects that there should be bio-medical solutions. Reproductive technologies are commonly perceived as being a solution. In the main, the participants rejected reproductive technologies, ostensibly because of the cost involved. However, their objections against medical interventions such as egg or sperm donation and surrogate mothering were mostly based on social and cultural mores. They underline the importance given to the social and cultural meanings of biological motherhood on the Cape Flats.

Just as infertility is not solely defined in bio-medical terms on the Cape Flats, treatment options for infertility are not restricted to the conventional. Infertile women

very often employ alternative treatment when medical treatment is unsuccessful or inaccessible. Alternative treatment has advantages and disadvantages but infertile women mostly view a specific treatment as an option only if it is socially and culturally acceptable.

When all treatment fails to produce the expected results, infertile women either have to accept their infertility or consider adoption. Adoption is not the ideal solution; adoptive motherhood does not carry the same social status as biological motherhood, because one is not rearing children born from one's own body. Inhorn (1996) states in a comparable study that to be a normal woman in Egyptian society you must be a normal mother, with the emphasis on offspring being from your own body. "One's gendered identity thus revolves around being the mother of the child of one's body." Inhorn (1996:63) says that all substitutes, including remaining childless, adoption, fostering or seeking employment, are unacceptable alternatives.

Thus, for infertile women, there is a need to find resources which will enable them to become biological mothers. Again this is due to the social and cultural importance ascribed to motherhood in the communities of the Cape Flats.

This is also in line with the main argument of this study; that infertility should not be seen solely as a bio-medical issue, but as one which includes the associated social and cultural meanings. While infertility is most often due to a bio-medical problem, it is the social and cultural implications of the inability to reproduce which is most influential in the daily lives of women living on the Cape Flats.

## Appendix 1: Letter to “Asking Amy” at the Community Newspapers

From: Bianca Davids;  
To: amyt@incape.co.za  
Date: Thu, 23 Mar 2006 12:38:19 SAST  
Subject: Research  
Dear Amy,

My name is Bianca Davids. I am a Masters student in Gender Studies at UCT. My research for this year will look at young coloured women's experience of infertility and how this impacts on their everyday life within the context of the Cape Flats.

For this research to commence successfully, I need to engage and interview young, married coloured women between the ages of 20 and 25 who have experienced any infertility/reproductive problems. I am appealing especially to the young woman who sought information on infertility treatment in your column a few weeks ago, or any other women who fit this profile, to contact me on 084 XXX XXXX.

Furthermore, it is important to mention that I am aware of the sensitive nature of this topic and guarantee all parties willing to participate the necessary sensitivity and confidentiality with regard to what will be said in our interviews.  
I would appreciate your help.

Thanking you in anticipation.

Yours sincerely,  
Bianca Davids

XX Devonshire Road  
XXXXXX  
XXXX

## **Appendix 2: E-mail sent to *The Daily Voice* (Pam Naidoo)**

From: Bianca Davids;  
To: pamn@incape.co.za  
Date: Thu, 21 Jun 2006 09:06:19 SAST  
Subject: Advert for participants in research study

Hi Pam,

I am researching infertility amongst young women on the Cape Flats. The ad that I would like to place in your newspaper should read:

“Looking for women between 20 & 30 who are struggling to fall pregnant, to be interviewed as part of a masters research study. Will pay R20 per interview. SMS or phone Bianca Davids at 084 XXX XXXX.”

I look forward to receiving your quote.

Regards,  
Bianca Davids  
Tel. (021) 703 XXXX  
Cell. 084 XXX XXXX



### Appendix 3: Advertisement placed in *The Daily Voice*

LOOKING FOR women  
between 20 & 30 who  
are struggling to fall  
pregnant, to be inter-  
viewed as part of a  
national research  
study. Will pay \$200  
per interview. \$500 or  
phone Brian Davis  
at 604 439 7610.

*The Daily Voice*, Wednesday, 5 July 2006, p. 18

LOOKING FOR women  
between 20 & 30 who  
are struggling to fall  
pregnant, to be inter-  
viewed as part of a  
national research  
study. Will pay \$200  
per interview. \$500 or  
phone Brian Davis  
at 604 439 7610.

*The Daily Voice*, Thursday, 6 July 2006, p. 18

LOOKING FOR women  
between 20 & 30 who  
are struggling to fall  
pregnant, to be inter-  
viewed as part of a  
national research  
study. Will pay \$200  
per interview. \$500 or  
phone Brian Davis  
at 604 439 7610.

*The Daily Voice*, Friday, 7 July 2006, p. 33

## Appendix 4: Letter written by supervisor requesting permission to conduct research

UNIVERSITY OF CAPE TOWN



### African Gender Institute

46 Maza House, University of Cape Town,  
Rondebosch 7701, South Africa  
Telephone: (27) 21 460 2522  
Fax: (27) 21 460 2142  
Email: [adgi@humanities.uct.ac.za](mailto:adgi@humanities.uct.ac.za)

Email address: [esaloo@humanities.uct.ac.za](mailto:esaloo@humanities.uct.ac.za)

21 April 2006

The Health Director of Cape Town  
Dr. Ivan Tems  
Cape Town

Dear Dr. Tems

#### Permission sought to conduct research at Manenberg clinic

I write to you on behalf of Ms. Bianca Davids, a student registered for the MA degree in the African Gender Studies at the University of Cape Town. Ms. Davids, who is working under my supervision, wishes to conduct research in Manenberg on the impact of infertility on young adult women's perceptions of their femininity, and attitudes of the wider community to these women when knowledge of their infertility becomes known. In order to conduct the research she would require the assistance of the staff at the local health clinic in Manenberg to help her identify potential interviewees. We are therefore requesting of you to provide Ms. Davids with the necessary permission to use the clinic as a primary research site in which she could gain access to potential interviewees.

Ms. Davids will be using a mix of research methods, including a short survey, in-depth interviews and life histories with the women who fit her research population profile. She is sufficiently apprised of the ethical considerations that she must adhere to, when conducting research with human subjects. She understands that she needs to explain the aims of the research clearly to all potential participants in a language that they understand; that she requires all participants' written permission to participate in the research and that participants cannot be made to participate involuntarily. She also further

#### **Appendix 4 continued: Letter written by supervisor requesting permission to conduct research**

*understands that research participants are free to end the research relationship at any point; that all interviewees will be provided with written assurance of confidentiality if they decide to assist her and that they must be provided with a research report at the end of the research period, to given in a suitable format that would make the findings readily comprehensible to them.*

We are including a copy of Ms. Davids' proposal as well as a copy of the confidentiality form for your perusal and to assist you in your decision.

If you have any further questions about this research project, please do not hesitate to contact me at the above mentioned telephone and fax numbers or by email. We thank you attending to our request.

Yours truly,

Dr. Elaine R. Sato  
Supervisor

Ms. Bianca Davids  
M.A. Student  
Student number DVDB1A002

## Appendix 5: Confidentiality agreement

### CONFIDENTIALITY AGREEMENT:

As a participant in this study, I \_\_\_\_\_ hereby understand the following terms stipulated in this agreement as explained by the researcher:

1. The information disclosed to the researcher will be treated with the strictest confidentiality.
2. My identity will be protected through the use of a pseudonym- assigned by the researcher or myself.
3. The information disclosed in the research process will only be used for academic purposes.
4. I am under no obligation to reveal sensitive information, which I feel unsafe or uncomfortable to disclose.
5. I am partaking in this study on a voluntary basis.
6. I know that I can terminate my participation in this study, whenever I want.

As the researcher, I Bianca Davids hereby agree to the following obligations with regard to the participant:

1. I will treat the information disclosed by the participant with the strictest confidentiality.
2. I will not disclose the participant's identity to any outside stakeholders or persons and protect their identity at all costs.
3. The information gathered during the research process will only be used for academic purposes.
4. I will not coerce the participant to disclose information, which they regard as being sensitive.
5. I will not bribe or make false promise to the participants in a quest to prevent them from terminating our relationship or to elicit certain sensitive facts.

The following signatures signify that both parties understand and agree to the terms stipulated in this agreement:

\_\_\_\_\_  
(Participant)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Researcher)

\_\_\_\_\_  
(Date)

## Appendix 6: Official permission letter from Dr. Claassen



CITY OF CAPE TOWN | 021 460 8700 | 021 460 8700

City Health Office  
Cnr. N.Y. 1 & Lansdowne Rd.  
Guguletu  
7750

Author: Dr J. Claassen

Tel: (021) 460 8700

Fax: (021) 460 8700

E-mail: [JCLAAS@cityofcape.gov.za](mailto:JCLAAS@cityofcape.gov.za)

Web: <http://www.cityofcape.gov.za/health>

Ref:

City Health Office  
Cnr. N.Y. 1 & Lansdowne Rd.  
Guguletu  
7750

Author: Dr J. Claassen

Tel: (021) 460 8700

Fax: (021) 460 8700

E-mail: [JCLAAS@cityofcape.gov.za](mailto:JCLAAS@cityofcape.gov.za)

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City Health Office  
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Guguletu  
7750

Author: Dr J. Claassen

Tel: (021) 460 8700

Fax: (021) 460 8700

E-mail: [JCLAAS@cityofcape.gov.za](mailto:JCLAAS@cityofcape.gov.za)

Web: <http://www.cityofcape.gov.za/health>

Ref:

City Health Office.

DATE: 10 May 2005  
To: Ms B. Davids  
CC:

You are hereby authorised to conduct research at Manenberg Clinic as requested by yourself and discussed telephonically with me earlier this month. As stated, City Health puts a very high premium on the confidentiality of the information gathered in our facilities and we trust that you will honour the commitment you have made to secure and respect any information which may be passed on to you.

May we take this opportunity of wishing you well in your endeavour and trust that you will develop a good working relationship with the City Health staff and whatever bonds formed now, will be carried into the future and that our staff and clients will continue to benefit from this interaction even after your research is completed.

Yours sincerely

Dr James Claassen MB ChB (UCT)  
City Health Klipfontein Sub-district  
Cnr. N.Y. 1 & Lansdowne Rd.  
Guguletu

## Appendix 7: Notices given to Sister Williams

### Appendix 7.1: Notice in Afrikaans

# OP SOEK NA...

...jong vroue tussen die ouderdom van 20-25 jaar oud, wat sukkel om swanger te raak. As jy gewillig is om in 'n onderhoud deel te neem vir navorsing oor infertiliteit, skryf asseblief jou naam op die vorm neer. As jy ouer is as 25, en jy is gewillig om deel te neem, skryf ook asseblief you naam neer.

**Name**

**Tel. Number**


# LOOKING...

...for young women from 20 to 25 years of age who are struggling to fall pregnant. If you are willing to be interviewed for a research study on infertility, please write down your details on the form. If you are older than 25, please feel free to write down your details.

Name	Tel. Number
Mr. Smith	0123 456789
Ms. Jones	0987 654321
Mr. Brown	0112 334455
Ms. White	0223 445566
Mr. Green	0334 556677
Ms. Black	0445 667788
Mr. Grey	0556 778899
Ms. Gold	0667 889900
Mr. Silver	0778 990011
Ms. Copper	0889 001122
Mr. Iron	0990 112233
Ms. Zinc	1001 223344
Mr. Nickel	1112 334455
Ms. Lead	1223 445566
Mr. Tin	1334 556677
Ms. Aluminum	1445 667788
Mr. Magnesium	1556 778899
Ms. Potassium	1667 889900
Mr. Sodium	1778 990011
Ms. Calcium	1889 001122
Mr. Barium	1990 112233
Ms. Strontium	2001 223344
Mr. Rubidium	2112 334455
Ms. Cesium	2223 445566
Mr. Francium	2334 556677
Ms. Actinium	2445 667788
Mr. Thorium	2556 778899
Ms. Protactinium	2667 889900
Mr. Uranium	2778 990011
Ms. Neptunium	2889 001122
Mr. Plutonium	2990 112233
Ms. Americium	3001 223344
Mr. Curium	3112 334455
Ms. Berkelium	3223 445566
Mr. Californium	3334 556677
Ms. Einsteinium	3445 667788
Mr. Fermium	3556 778899
Ms. Mendelevium	3667 889900
Mr. Nobelium	3778 990011
Ms. Lawrencium	3889 001122
Mr. Rutherfordium	3990 112233
Ms. Dubnium	4001 223344
Mr. Seaborgium	4112 334455
Ms. Bohrium	4223 445566
Mr. Hassium	4334 556677
Ms. Meitnerium	4445 667788
Mr. Darmstadtium	4556 778899
Ms. Roentgenium	4667 889900
Mr. Copernicium	4778 990011
Ms. Nihonium	4889 001122
Mr. Flerovium	4990 112233
Ms. Tennessine	5001 223344
Mr. Oganesson	5112 334455

[illegible]

# LOOKING...


...for young women from 20 to 25 years of age wat sukkel om pregnant to raak. As jy gewillig is om geïnterview te word vir a research study op infertility, skryf asseblief jou details neer op die vorm. As jy ouer as 25 is, also feel free to write down your details.

Name

Tel. Number



**Please write down the details of young women who are seeking infertility treatment (problem falling pregnant) and are willing to be interviewed for the infertility study by Bianca Davids.**

The image shows a large, light gray watermark of the University of Cape Town logo, which is a circular emblem containing a stylized building and the university's name, overlaid diagonally across the entire page.

IS JY TUSSEN 20 EN 30  
JAAR OUD?  
SUKKEL JY OM  
SWANGER TE RAAK?  
AS JY MET MY DAAROOOR  
WIL PRAAT...  
KONTAK BIANCA DAVIDS  
TEL: 703 XXXX (H)  
(TUSSEN 11:00AM EN  
5:00PM)  
CELL: 084 XXX XXXX

## Appendix 10: Introductory letter

Dear Participant.

I am currently conducting research on infertility amongst women on the Cape Flats. I want to explore what people think about infertile women in the Coloured communities of the Cape Flats and how these women themselves feel about infertility and what they are doing about it.

I am requesting your participation in this research in order to help me answer these questions accurately.

The information you provide in the research process will be treated with the utmost sensitivity and confidentiality (see enclosed confidentiality agreement). As a woman who her herself has been labeled 'infertile', I understand that the questions around infertility is very sensitive. I understand infertile women's experiences and their suffering. I am not here to judge. I am here so that YOU can tell me YOUR Story, so that YOUR VOICE can be heard in a study about an issue that is little researched.

Your participation in this study is highly appreciated. Your participation will contribute to the knowledge and awareness of infertility on the Cape Flats.

Regards  
Bianca Lee Davids

## **Appendix 11: Indemnity agreement**

### **INDEMNITY AGREEMENT**

I, Bianca Davids hereby state that I am not responsible for any false expectations on the part of the participant in terms of the benefits of the research. I do not own a 'miracle drug' for infertility. During correspondence prior to the first interview, I did not promise the participant direct access to any infertility treatment or any access to infertility medication. However, I agree to advise participants about private and public health facilities, they could possible seek infertility treatment as well as providing advice about their condition to the best of my knowledge. If I do not have the answers to certain questions, I will try to find the answers, to the best of my abilities.

I regret if it was the expectation of any of the participants that I would provide direct access to infertility treatment. Considering that participation in this research is on a voluntary basis, I cannot stop a participant from terminating our relationship for my inability to provide access to infertility treatment.

I have explained the above mentioned to the participant. She understands that I do not provide a 'miracle cure' to infertility nor do I have neither access to any infertility drugs nor direct access to infertility treatment. She understand that I can provide advice about where she could possible seek treatment at public or private health facilities.

---

Miss Bianca Davids (Researcher)

---

(Date)

## Appendix 12: Basic Information Survey

### BASIC INFORMATION SURVEY:

The information contained in this survey will only be used for academic purposes by the researcher, Bianca Davids. The objective of this is to gather background information:

Please **CIRCLE** the **NUMBER** next to the response that applies to you. Fill in answers where space is provided for it.

#### Socio-demographics:

Name: \_\_\_\_\_

Pseudonym: \_\_\_\_\_

Age: \_\_\_\_\_ (please specify)

When were you born: \_\_\_\_\_

Where were you born: \_\_\_\_\_

Number of sisters: \_\_\_\_\_

Number of brothers: \_\_\_\_\_

Are the eldest, middle child or youngest? : \_\_\_\_\_

- |                               |                      |   |
|-------------------------------|----------------------|---|
| 1. I describe myself as ..... | Coloured.....        | 1 |
|                               | Cape Malay.....      | 2 |
|                               | Black.....           | 3 |
|                               | Indian.....          | 4 |
|                               | Other (specify)..... | 5 |

- |                                |                       |   |
|--------------------------------|-----------------------|---|
| 2. My main home language is... | Afrikaans .....       | 1 |
|                                | English .....         | 2 |
|                                | Isixhosa .....        | 3 |
|                                | Other (Specify) ..... | 4 |

3. Area of Residence (Please specify Township/suburb): \_\_\_\_\_

- |   |                              |   |
|---|------------------------------|---|
| 4. I am...(Please circle all that apply to you) |                              |   |
|   | Employed .....               | 1 |
|   | Unemployed .....             | 2 |
|   | Student/Scholar .....        | 3 |
|   | Self-Employed .....          | 4 |
|   | State Grant/Disability ..... | 5 |
|   | Other( Specify).....         | 6 |

## Appendix 12 continued: Basic Information Survey

5. If you are employed, what job do you have? :

---

6. Highest level of education is ....
- |                                  |   |
|----------------------------------|---|
| Less than Grade 12 (Matric)..... | 1 |
| Grade 12 (Matric) .....          | 2 |
| Certificate .....                | 3 |
| Diploma .....                    | 4 |
| Degree .....                     | 5 |
7. I am (answer **ONE** only) .....
- |                               |   |
|-------------------------------|---|
| Married .....                 | 1 |
| Long term relationship .....  | 2 |
| Short term relationship ..... | 3 |
| Separated .....               | 4 |
8. How long have you been together with your current partner?
- |                          |   |
|--------------------------|---|
| 3 to 6 months .....      | 1 |
| 6 to 12 months .....     | 2 |
| 1 to 5 years .....       | 3 |
| 5 to 10 years .....      | 4 |
| More than 10 years ..... | 5 |

### Health Status:

9. Apart from my infertility, I consider my health to be .....
- |                 |   |
|-----------------|---|
| Excellent ..... | 1 |
| Good .....      | 2 |
| Average .....   | 3 |
| Poor .....      | 4 |
| Very poor ..... | 5 |

10. How long were you trying to fall pregnant? : \_\_\_\_\_

11. What made you decide to seek medical treatment? \_\_\_\_\_

---

12. Have you been diagnosed?
- |           |   |
|-----------|---|
| Yes ..... | 1 |
| No .....  | 2 |

If the response is yes, to the previous question, please specify condition:

---

## Appendix 12 continued: Basic Information Survey

### Fertility test:

The following test appeared in 'The Fertility Handbook' by Joseph Bellina and Josleen Wilson and has been adapted to suit the purposes of this research. This test is given to women at a fertility clinic in America to determine a woman's chances of having a fertility problem. The results of the test are withheld due the researcher, questioning of the reliability of the results and to avoid unnecessary worry on the part of the participant because the results represents a statistical chance.

#### ***THE FERTILITY RISK QUIZ FOR WOMEN:***

Choose the answer that most closely applies and write the corresponding number of points on the appropriate lines in the right hand column:

- |  | Points. |
|--|---------|
| 1. You first had intercourse when you were:                  |         |
| • 12 years old (15 points)                                   |         |
| • 13-14 years old (10 points)                                |         |
| • 15-18 years old (5 points)                                 |         |
| • 19-21 years old (3 points)                                 |         |
| • 22-25 years old (0 points)                                 | _____   |
| 2. Your total number of sexual partners to date is:          |         |
| • 1-3 (1 point)  |         |
| • 4-7 (5 points)   |         |
| • 8-15 (10 points)   |         |
| • 16 or over (25 points)                                     | _____   |
| 3. You started to menstruate at:                             |         |
| • 10 years old (0 points)                                    |         |
| • 11-14 years old (1 point)                                  |         |
| • 15-18 years old (5 points)                                 |         |
| • 19 or over (10 points)                                     | _____   |
| 4. How normal are your menstrual cycles?                     |         |
| • Regular (0 points)   |         |
| • Slightly irregular (5 points)                              |         |
| • Very irregular (10 points)                                 | _____   |
| 5. How many hospital-treated pelvic infections have you had? |         |
| • None (0 points)  |         |
| • One (5 points)   |         |
| • Two or more (10 points)                                    | _____   |
| 6. Have you had gonorrhea?                                   |         |
| • No (0 points)  |         |
| • Once (5 points)  |         |
| • More than once (20 points)                                 | _____   |

## Appendix 12 continued: Basic Information Survey

7. What is the total number of years you have used birth control pills?

- Never (0 points)
- 1-3 years (1 point)
- 4-6 years (3 points)
- More than 6 years (20 points)

\_\_\_\_\_

8. How many years have you used an IUD ("the loop")?

- Never (0 points)
- 1-3 years (5 points)
- 4-6 years (10 points)
- More than 6 years (20 points)

\_\_\_\_\_

9. Have you ever developed vaginal warts?

- No (0 points)
- Yes (3 points)

\_\_\_\_\_

10. How many abortions have you had?

- None (0 points)
- One (3 points)
- More than one (5 points)

\_\_\_\_\_

11. For how many years have you tried to become pregnant?

- 1-2 years (5 points)
- 3-5 years (10 points)
- 6 or more years (15 points)

\_\_\_\_\_

12. Do you have menstrual cramps?

- Mild or none (0 points)
- Moderate (3 points)
- Severe (5 points)

\_\_\_\_\_

13. Do you feel during intercourse?

- Little or none (0 points)
- Moderate (3 points)
- Severe (5 points)

\_\_\_\_\_

14. Your current age is:

- 18-24 (0 points)
- 25-29 (5 points)
- 30-35 (10 points)
- 36-40 (15 points)

\_\_\_\_\_

(if you are unclear about any of the questions, please feel free to ask me)



## Appendix 13: Doctor's report

### Medical Report on Patient

28/11/06

### To Whom It May Concern:

The above is 27 G1P0 with the problems of:

#### **1.Secondary Infertility**

#### **2.Polycystic Ovarian Syndrome**

She presented to me complaining of 8 years of attempting to fall pregnant on no contraception.

Her periods were very irregular and only had her period every 2<sup>nd</sup> to 3<sup>rd</sup> month.  
She also had occasional deep dyspareunia.

Her husband has no history of trauma and has a normal semen analysis.

She has no past medical or surgical history of note.

Examination revealed slightly overweight patient with truncal obesity.

Her thyroid and breasts were normal.

Her abdomen was soft and non tender.

The vaginal examination was normal.

Trans vaginal ultrasound revealed bilateral polycystic ovaries.

I performed a thyroid function which was normal and a glucose/insulin ratio which showed marked insulin resistance.

I have prescribed Metformin for her but have counselled her that she may need Ovulation induction to fall pregnant.

Yours truly,

Dr Bruce Howard  
Obstetrician and Gynaecologist

## Appendix 14: Interview schedule 1

### INTERVIEW 1: LIFE HISTORY:

I would appreciate it if you could tell me about your life, so that I can understand your position in society:

(Some extra questions have been added that were brought up in interview 1 with the first participant)

- Can you tell me about your parents?
  - Where are they from?
  - What did your father do for a living?
  - What did your mother do for a living?
  - How did they feel about your birth? Were you a planned baby or a surprise?
- Tell me about your childhood?
  - Where did you stay during that period of your life?
  - Who did you spend most of your time with during that time?
  - Are there any memories that stand out from that time?
- Tell me about your teenage years?
  - Did you receive any sexual education at high school?
  - Do you think that schools should provide sex education?
  - Did your parents ever discuss these issues with you? If no, where did you get your information from?
  - Where did you stay?
  - With whom did you spend most of your time?
  - Did you start dating when you were a teenager? What did your parents say about that?
  - How were you supposed to act as a good daughter within your parental home? Did you ever act against those expectations?
  - Did your parents have any expectations of what you would do with your life after school? What was more important - getting a career or getting married?
  - Are there any memories that stand out?
- At what age did you start menstruating?
  - What did your mother say to you when you got your first period?
  - Did your father say anything to you?
  - Did your parents start treating you differently after you got your period?
  - How did your friends treat you after your first period?
  - How did the rest of the family treat you after you got your first period?
  - After you got your first period, did you perhaps think that you were now different to being a child?

## Appendix 14 continued: Interview schedule 1

- How do you feel about people saying that a woman is sick when she has her monthly period?
- How long is your cycle?
- Have you ever suffered from irregular periods? If yes, did you seek medical treatment for it?
- Have you suffered from heavy and painful periods? If yes, did you seek medical treatment for it?
- Do you feel any changes in your body before your period?
- At what age did you start getting breasts?
- At what age did you start developing 'hips'?
- How did you feel about getting your breasts?
- How did you feel when you noticed that your body was taking a more feminine form?
- What did you do after school? Are you still doing that or has it changed?
- Personal medical history:
  - Did you hurt yourself seriously when you were a child like fall off your bike or fall out of tree or knock your head?
  - Have you suffered from any serious illnesses?
  - Have you had any eating disorders?
  - Is there a history of any illnesses in your family like diabetes or heart problems?
  - Is there a history of infertility or reproductive problems in your family?
  - Have you had a pelvic infection or any other infections 'down below'?
  - Have you ever had an abortion? If yes, how was it treated?
  - Have you ever had a miscarriage? If yes, how was it treated?
  - Have you ever had any surgery?
  - Do you use any contraceptives? If yes, what do you use and what have you used before?
  - Have you ever suffered from any other reproductive problems prior to your infertility?
- Are you currently in a relationship?
  - When did you meet your partner?
  - How long have you been together?
- When did you start trying to have a baby?
- How long were you trying before you realized there is something wrong?
- What were the symptoms that you were experiencing?
- How did you feel, thinking that there might be something wrong with you?
- Were you officially diagnosed?
  - If yes:
    - Did a doctor or nurse diagnose you?
    - What was the diagnosis?
    - What was your reaction to the news?
    - How do you feel about it now?

## **Appendix 14 continued: Interview schedule 1**

- If No:
  - Why did you see a doctor or nurse before about your condition?
  - What do you think is causing your condition?
- What are some of the things that come into your mind when you think about your condition?
- Do you think that your condition is beyond your control or in your control?
- Have you ever blamed yourself or your body for your infertility?
- Have you ever been depressed because of your condition?
- What gives you hope that one-day you will have a baby?
- Do you ever think that one day it will be too late?

University of Cape Town

## **Appendix 15: Interview schedule 2**

### **INTERVIEW 2: ACCESS TO MEDICAL RESOURCES:**

#### **Reproductive knowledge:**

- What knowledge do you have of human reproduction?
- Do you have basic knowledge about:
  - The female sexual anatomy? (Refer to figure 1)
  - The male sexual anatomy? (Refer to figure 2)
  - A woman's menstrual cycle (Refer to figure 3)
  - A woman's reproductive organs? (Refer to figure 4)
  - The best time in a women's cycle to fall pregnant?
- Has the doctor or anyone else explained to you about thing you could do to aid conception like the best time in your cycle to conceive? (For an example refer to figure 5)

#### **Some questions for women who said that they were not diagnosed in interview 1:**

- While the following questions may seem very personal, they could shed some light to you and me about the possible cause of your infertility:
  - Does your partner suffer from premature ejaculation or impotence?
  - Have you ever experienced pain during intercourse?
  - Do you know what ovulation is?
  - Do you know when you ovulate?
  - If yes, to previous question, do you try to increase your sexual activity during that time period?
  - Do you perform any cleaning activities after sex like washing out your vagina?
- How long have you tried to fall pregnant?
- Who was the first person that you told about your worries about not being able to fall pregnant?
  - What did that person say to you?
- At the time that you were trying to fall pregnant, did you gain or lose a lot of weight?
- Do you smoke or drink?

#### **Some questions for women who said that they had been diagnosed in interview 1:**

- How long ago were diagnosed?
- What did the doctor say is wrong with you?
- Did he explain what it is to you?
- What treatment did the doctor give you for your condition?
- Has the prognosis changed since then?
- I would like to ask you if you have heard of the following fertility tests:
  - Hormonal blood tests
  - Endometrial Biopsy

## Appendix 15 continued: Interview schedule 2

- Ultrasound
- Post-coitus test
- Stress counseling

If yes, were any of the test performed on you? If any of these tests haven't been used to diagnose infertility, what test was used to determine infertility?

- At the time that you were trying to fall pregnant, did you gain or lose a lot of weight?
- Did the doctor or nurse take this into consideration?
  - Your weight, your diet and your lifestyle?
  - How long you have been trying to fall pregnant?
- Do you smoke or drink?

### Access to medical resources:

- Do you mostly make use of private or public health facilities?
  - If public, do you think that infertility is seen as an important issue in the public health sphere? Why do you make use of the public health sector and not the private?
  - If private, do you think that infertility is seen as an important issue in the private health sector or is it just a moneymaking business? Why do you mostly make use of the private instead of public health sector?
- Are you receiving any treatment for your condition?
- Do you think that the treatment is sufficient (good enough)?
  - If yes, what makes the treatment that you are receiving good enough?
  - If not, what do you think you will need to get better treatment?
- Do you think that you are worse off or better off in terms of receiving infertility treatment than someone who has more money, a better education etc than you?
- Do you know where you can go for infertility treatment in the Western Cape?
  - Do you have access to these?
  - What would make them more accessible to the 'women on the street'?
  - Do you think that there is sufficient knowledge for women to know where to go for infertility treatment?
  - What would be needed to make women more aware of where to go for treatment?
- Are you shy or embarrassed to discuss personal issues with the doctor or with me as the researcher?
- Do you sometimes feel that doctors and nurses who provide infertility treatment have control over your life?

## Appendix 15 continued: Interview schedule 2

- Do you think that doctors and nurses are sensitive to your problems or do you feel that they just treat you as just another patient?
- Have you done any independent research on the cause of your infertility?
  - If yes, was it helpful?
  - If no, have you considered doing this?

### Alternative treatments:

- Do you only use medication prescribed by your doctor or do you use alternatives?
- Have you received any advice from friends or family about what to do to fall pregnant?
  - What did they say?
  - Have you tried any of their advice?
- I would like to show you an ad that I show in *You* magazine of 18 May 2006. The ad claims that their product is a hormone balancing formula that can improve your chances of falling pregnant? (Refer to figure 6)
  - Would you try this product based on this promise?
  - Do you think that it will work or is it just money making scheme considering that you have to take it for 3-6 months?
  - The ad states that there are two distinctive groups who struggle with infertility, namely young career women and women in second marriages. Why do you think they only mention these two groups?
- Do you know of any product that is specifically targeted at you?
- Have you seen any of these ads in the newspapers from herbalists who promise they can treat or cure infertility? (Refer to figure 7)
  - Have you considered seeking treatment from an herbalist?
  - If yes, why would you go that route?
  - If no, why would you not consider that option?
  - Do you think that if you sought treatment from an herbalist, it could be seen as using 'doekom'?
  - Do you think that they are talking nonsense or are there some truth in that?
  - Have you ever tried any herbal remedies that were advised from family or friends? What was the advice?
- Have you enquired about assistance from psychics or spiritual healers? (Refer to figure 8)
  - If they promised you that they could help you, would you try their advice?
- Have you seen any ads or posters advertising the "Miracle Crusades"?
  - Have you been to one?
  - Have you asked anyone to pray for you?
  - Do you think that they might possibly cure your condition?

## Appendix 15 continued: Interview schedule 2

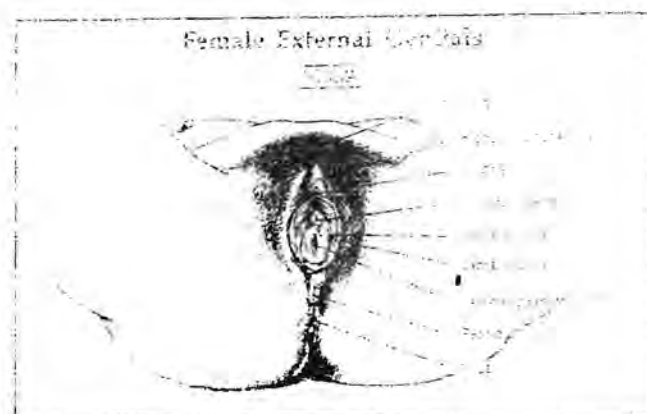
### Options:

- If you saw an advertisement in the newspaper looking for women to test a new fertility drug that could help you falling pregnant, would you volunteer although it's a new drug and the side effects are not known?
  - How would you feel if the drug didn't work?
  - How would you react if the drug does so much damage to your body that you will never be able to have children? Are you willing to take that risk?
- If you knew of an exclusive treatment that was beyond you financial means, would you consider that treatment as an option? What would you do to achieve that?
- What are the chances that you might conceive naturally?
- If you weren't able to have a child of your own (with treatment) what else would you do?
  - Would you consider In-Vitro Fertilization? Do you know what it is?
    - If yes, could you afford it?
    - If no, why would you not consider it?
  - Would you consider a surrogate mother? Do you know what it is?
    - If yes, whom would you ask?
    - If no, why would you not consider it?
  - Would you consider an egg donation? Do you know what it is?
    - If yes, would you ask someone you know for a donation and can you afford the medical costs?
    - If no, why would you not consider it?
  - Would you consider adoption?
    - If yes, could you afford it? And what would your specifications be?
    - If no, why would you not consider it?



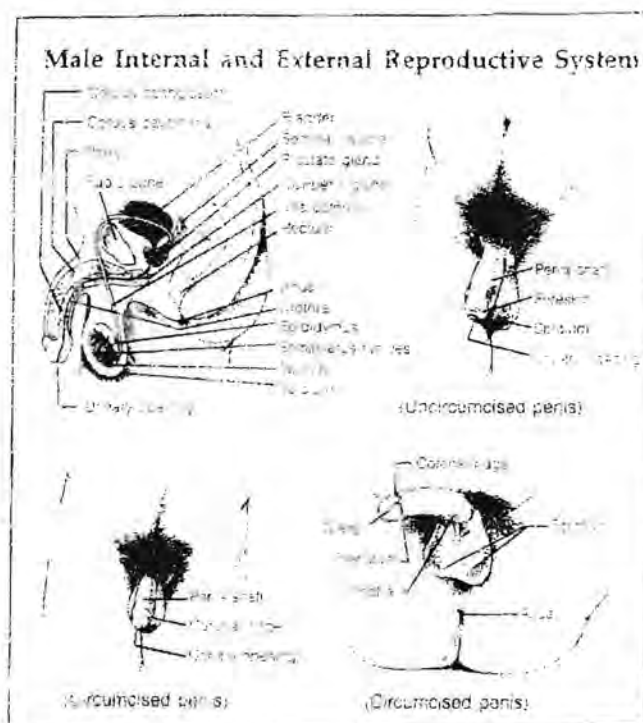
**Appendix 15 continued: Interview schedule 2**

**FIGURE 1: FEMALE SEXUAL ANATOMY**



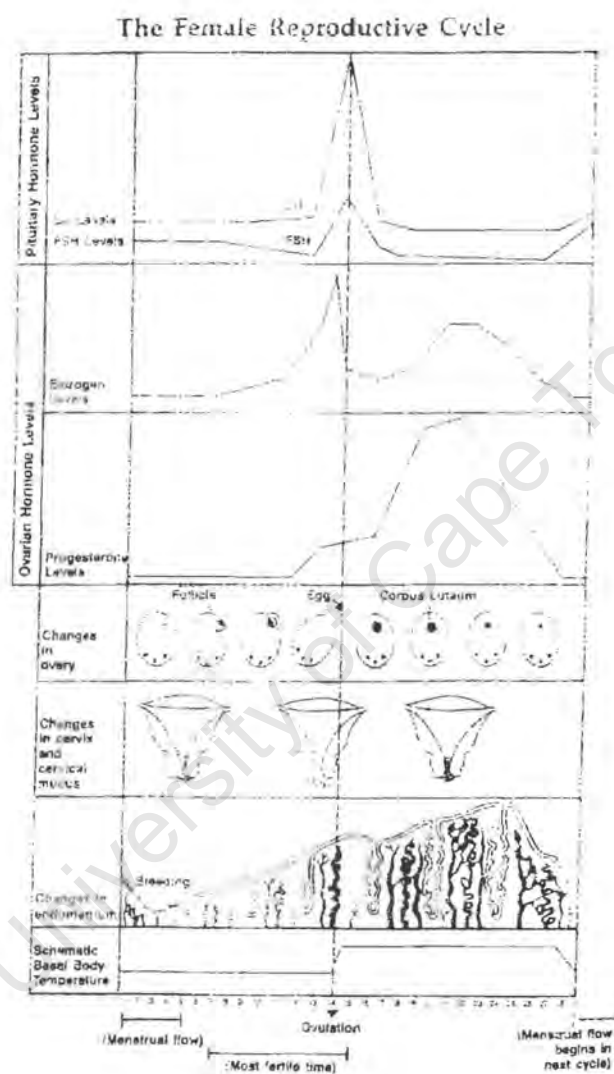
## Appendix 15 continued: Interview schedule 2

### **FIGURE 2: MALE SEXUAL ANATOMY**



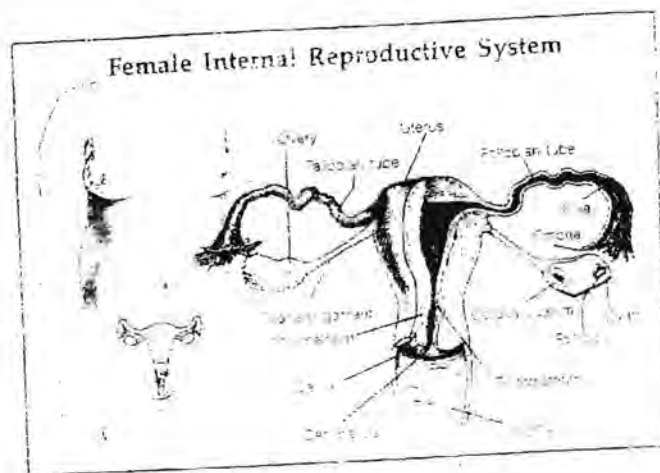
## Appendix 15 continued: Interview schedule 2

**FIGURE 3**




Appendix 15 continued: Interview schedule 2

**FIGURE 4: FEMALE REPRODUCTIVE ORGANS**



## Appendix 15 continued: Interview schedule 2

**FIGURE 5: OVULATION TEST**



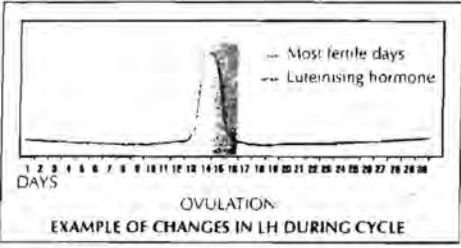
**Clearplan** Home Ovulation Test

**SURGE LINE** **REFERENCE LINE**

**RESULT WINDOW**

**W**hen you've made up your mind that it's time to have a baby, the crucial thing to know is when you are most likely to get pregnant.

The likelihood of getting pregnant increases when you make love on the days approaching ovulation when you release an egg, and is at its highest on the day of ovulation. The Clearplan Home Ovulation Test detects the surge of luteinising hormone in your urine which normally occurs 24 - 16 hours before ovulation, and therefore tells you the days when you have the best chance of conceiving.



**EASY**  
A simple way to detect your most fertile time - there is no need to record your temperature, keep charts or carry out messy procedures. Simply hold the absorbent sampler in your urine stream for five seconds and wait 3 minutes for the result. It's as easy as that.

**CLEAR**  
Clearplan Home ovulation Test provides a clear, easy-to-read result which tells you whether or not you are about to ovulate.

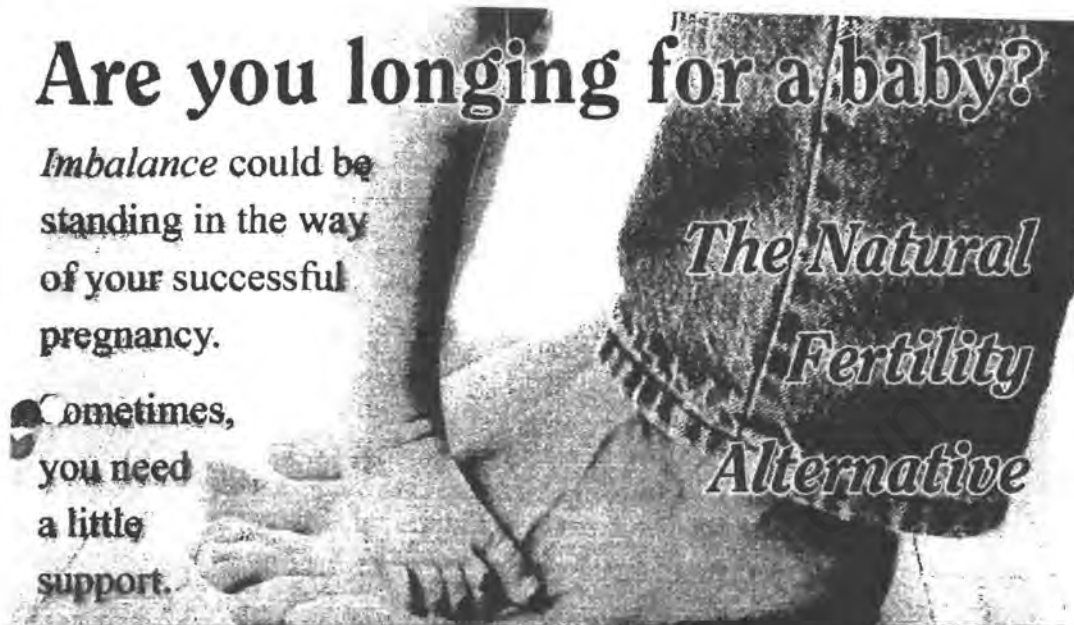
**CONVENIENT**  
Simply test for a few days each cycle. Clearplan can be performed at any time of day and each daily test just a few minutes.

**HIGHLY ACCURATE**  
Clearplan is 99% accurate in detecting the rise in luteinising hormone which precedes ovulation.

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FIGURE 6: HORMONE BALANCING FORMULA



# Are you longing for a baby?

*Imbalance could be standing in the way of your successful pregnancy.*

**Sometimes, you need a little support.**

## The Natural Fertility Alternative

**PROVEN POSITIVE RESULTS WITH:**

- 1 Hormonal imbalances
- 2 Irregular cycles
- 3 Anovulatory cycles
- 4 Endometriosis
- 5 Mild polycystic ovarian syndrome
- 6 Low sperm count, morphology & motility

*"I had been struggling to fall pregnant for 7 years, had endometriosis, undergone 8 operations and suffered two ectopic pregnancies. I had been told by doctors that there was very little, if any hope, of ever conceiving. There was nothing more they could do for me. My worst fears were becoming a reality. In October, I started on Ferti-boost. My periods regulated to 28 days and I had more energy and less mood swings. 3 months later my doctor confirmed I was pregnant! Thank you... Dr Colin & Ferti-boost!"*

*Linda Brewer*

**For all the women struggling to conceive two groups are most distinctive. The driven 'career girl' and the woman in her second marriage.**

A driven young woman does not always realise that her body may have passed its baby-making prime by the time she is ready to settle down. Pushing her body combined with years of contraception creates a hormonal roller coaster that results in a drain on her reproductive resources.

The woman in her second marriage is a dedicated mom who having met Mr Right now wants a child with him.

The biggest problem for men is that sperm problems present with no external symptomology and a seemingly healthy man has no idea he may not be 100% fertile.

Both these situations take their toll and are often the cause of difficulties in falling pregnant. The demands on the body due to the sheer pace of life result in a depleted ability in both men and women to have children.

**Ferti-boost™ is a natural hormone balancing formula for men and women, which can safely and effectively improve your chances of conception. Recommended over a 3 - 6 month period.**



For more information contact

Elizabeth Savage

Tel +27 (0)31 267 5882/70

Fax +27 (0)31 267 5884

info@drcolins.com

www.fertiboost.com



**DR COLIN'S**

Reproductive Health

**Ferti-boost™**

# Appendix 15 continued: Interview schedule 2

## FIGURE 7: HERBALIST ADVERTISEMENTS

**AYAWO HERBALIST**

- Bring back lost loved ones
- Love, marriage, divorce, bad luck, curses, "tokoloshe" (evil spirits), removal of negativity / evil from home, business, lucky bags, and so much more!
- I work nationwide and internationally for clients. Sorry, no advice or herbs are given for medical problems.
- Cases are also done telephonically, by post, fax or e-mail. Give me a call NOW and let's change your life for the better! (All cases strictly confidential)

**CONTACT DR AZANGE ON 072 740 0152**

---

**MALUNGO HERBALIST**

- Bring back lost loved ones
- Love, marriage, divorce, bad luck, curses, "tokoloshe" (evil spirits), removal of negativity / evil from home, business, lucky bags, and so much more!
- I work nationwide and internationally for clients. Sorry, no advice or herbs are given for medical problems.
- Cases are also done telephonically, by post, fax or e-mail. Give me a call NOW and let's change your life for the better! (All cases strictly confidential)

**CONTACT DR AZANGE ON 072 740 0152**

**AZANGE MAGIC**

Are you tired of paying for something with no results? Now, worry not. I am the powerful traditional healers to free all your unsolved problems. I was honoured by specialising in Nlungu fruits for penis enlargement, big court cases, get your job back even if the boss has dismissed you. Your Loved one is taken, you want him/her back, even if you do not see it talk to each other, lotto, casino, horses, rats, Jinns, magic stick & whirlwind for financial security and more. My work has a high success rate. Call Dr Azange 072-740-0152

**SANGOMA**

Need help to improve your "situation"? Let the ancient wisdom help you with:

- Love, marriage, relationships, divorce, bad luck, curses, "tokoloshe" (evil spirits), removal of negativity / evil from home, business, lucky bags, and so much more!
- I work nationwide and internationally for clients. Sorry, no advice or herbs are given for medical problems.
- Cases are also done telephonically, by post, fax or e-mail. Give me a call NOW and let's change your life for the better! (All cases strictly confidential)

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sangoma@freesat.net

**DR. AKWEYA**

He is the specialist in:

- Penis enlargement
- Remove tokoloshe and binding houses
- Court cases
- Bring back lost lover
- To get married
- Jailer women who don't produce
- Money problems
- Assist with Winning the Lotto, Casino & at the horses
- Rats sick magic
- House for bringing money
- Kwekwe
- Assist in finishing unfinished job
- Mkwere oil for luck

Send order and fortune telling over the phone free

Contact me on 084 321 4455 or visit me at 56275 Diale Crescent, Hwange, Cape Town

**DR MUBARAK HERBALIST**

The strongest Master in Herbs. Good news to all looking for quick & genuine results. I solve all kinds of problems. 24 hrs guaranteed. Relationships, sexual problems, penis enlargements, financial recovering lost property, lucky charm, boosting business, casino, lotto, sendawana oil to get money, binding homes, business, court cases, promotions at work, remove unwanted people, evil spirits etc. Be the winner. No matter how big your problem is, I will solve it!

**(031) 301-7524 / 072-819-7450 or 073 703 6311, Durban.**

**MGOLONJE TRADITIONAL HERBALIST**

Do you have problems in your love, affairs, marriage, or family? Tokoloshe, witchcraft, troubling you? Lost love, back, boosting your business, and criminal cases and many more!

Contact 073 597 6227 or 073 3258 028 or 021 388 5130  
Ngonjole Nyanga

**DR NYATHUKA CERTIFIED MAIL ORDER HERB SPECIALIST**

Challenges big issues - only. Boosting business, financial problems, court cases, prisoners out free, removing unwanted persons, All jobs are guaranteed such as penis enlargement, bring back lost loves. Only 3 hrs, lotto, get rich by using Mvema and Vambela and also those who are having a difficult pregnancy.

**CALL NOW - 072-918-4633**

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TO HELP WITH YOUR PROBLEMS AND DISEASES

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073 234 7100

**CHIEF MKWANDA**

Here comes a herbalist who is challenging. For all people who are desperate in their lives. Mkwanda is here to solve all your problems such as unfinished jobs where others failed, hire Jinns. Bring back lost lovers, get a job or a promotion, boost your business, sexual problems, Lucky charms, bring back lost items and many more. If you are far I will post by speed mail.

**PHONE HIM AT 073-968-0165**

**THE POWERFUL NJIWA IS HERE TO HELP EVERYONE!!**

I'm a specialist of:

- Bringing back your lost lover
- Court cases
- Penis enlargement in 12 hours
- Lucky charm Casino, Lotto
- Chase away Tokoloshe
- Stop drinking beer

For more information Contact Dr Njwa - 073 284 2642

**YAKWE YAKWE HERBALIST**

**THE DOCTOR THAT HAS NEVER FAILED**

I'm a specialist to bring back your lost lover within 3 hrs, time guaranteed, separating lovers, powder for lover proposal, financial problems. If you want to win big money through casino or lotto, I will help you. Dr Yakwe Yakwe also does penis enlargements and erection within 15 hours, guaranteed. To chase tokoloshe away, binding your house or cars, to win court cases, pass exams at school and much more. Dr Yakwe Yakwe, he challenges you and has never failed at all. I promise you all my jobs are 100% guaranteed. One call will change your life forever. Dr is in Durban. Why not try him? Contact Dr Yakwe Yakwe on 072 351 8193 or 072 815 0979. Call Dr Yakwe Yake, all hours.

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Are you tired of crying?? I'm here to help. Have had success over the past 20 years. "Double your money" "No game"

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- Financial problems
- Court cases
- Business
- Lotto/Casino

Phone me today and change your life no matter where you are. Money back guarantee!!

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**DOCTOR MASUKU**

Here is the most powerful African doctor you have been waiting for. He is now around in R.S.A. to solve problems affecting the entire mankind on earth. Dr Masuku is a well trained in all sorts of your problems. He is specialising in the following problems:

- Amagudane to bring money home, Rainbow water and sendawana
- Men who have no power, who have a small penis. Dr Masuku makes big financial problems, you will never struggle again
- For gambling, lotto, casino, and dream horse number
- Protecting your properties like binding your house
- Bringing back your lost lover within 48 hours
- Women to be liked more by their partners
- Enlargement for men guaranteed
- Women who have problems (water) during sex. Dr Masuku can solve that problem immediately
- Be promoted at work
- Be usually strong in bed for men and women. He uses all sorts of oil to bring money to your house. Work on like Mvema everything is possible

**Dr MASUKU MAIL ORDER - 073 940 0662**

## Appendix 15 continued: Interview schedule 2

**FIGURE 8: PSYCHICS & WICCANS**

**Magic in the Bottle**

Plus **FREE** luck charm

For enquiries and orders please sms me at **4 970 3919** and I will contact you back.

An ancient magic secret, which has worked for thousands of years.

**Three Magic Bottles**

For love, luck, money and the Magic Bottle will put you the person you love, the money you desire, lotto, casino and plenty of luck in whatever you do. You'll get this all in the three Magic Bottles.

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Is here for you

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SMS your question to **36368** and you will receive an instant answer.

Secret Sue can help you with all your problems. Positive or negative, or anyone taking her advice.

**POWERFUL SPELL KITS PERSONALLY 'WORKED' FOR YOU - TO BRING YOU WHAT YOU WANT**

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## Appendix 16: Interview schedule 3

### INTERVIEW 3: PERCEPTIONS OF INFERTILITY:

#### Talking about it:

- How open are you about your infertility?
- Does your mother know about your condition?
  - What does she say about it?
  - Does her opinion count?
- Have you told any male or female family member about your condition?
  - What were their reactions?
  - What did they say to you?
- Do other people often ask you when you will have children?
  - What do you say?
- Have you ever lied to someone about why you don't have children?
  - What did you tell them?

#### The Silence around infertility:

- Do you think that people talk about infertility in your area, community, church, and/or mosque?
  - If yes, what do they say?
  - If no, why do you think people don't talk about it?
- Do you think that infertility is a terrible thing to happen to a woman?
- Do you know of any other infertile women in your community?
  - Do you talk to them?
  - What do you talk about?
- Are women afraid to tell people that they can't have children?
  - Who do they fear the most?
  - What do they fear they will say?
- What is the worst thing that someone can say to a woman who can't have children?
- What do you think people in your community would say if they knew you couldn't have children?
  - Do you think that they will gossip about it?
- Do you feel that people pity women who cannot have children?

#### Perceptions of the infertile woman:

- How do other mothers treat you?
- How do you behave around other women's children?
- Do you think that you could relate to other women who are infertile? Why?
- Can a woman be seen as a true woman if she doesn't have any children?
- I would like to read you a statement that I read in a book called 'In Search of Parenthood' (by Judith Lasker and Susan Borg) and ask you three questions about it:

## Appendix 16 continued: Interview schedule 3

*“A lot of people don’t understand that infertility is very much like having a chill die. You grieve for the baby who wasn’t conceived this month, and for all the babies you’ll never have”*

- How do you feel about this statement?
  - Do you relate to his statement?
  - Do you think women really feel this way about their infertility?
- Do you think the world is sympathetic to infertile women?

### Women not deserving to be mothers:

- How do you feel about women:
  - Who fall pregnant and then choose to have abortions?
  - Who have a lot of children?
  - Who physically abuse their children?
  - Who sexually abuse their children?
  - Who neglect their children?
  - Who abandon their babies?
- Do you think they are worthy of being called mothers?
- Who do you think mothers do such things to their children?

### Religious beliefs:

- What religion are you?
- What does your religious beliefs say women and motherhood?
  - Does it mention anything on infertility?
  - What does it say?
  - Does your religious belief punish unwed motherhood? If yes, what do they do?
  - Taking this punishment into consideration, would you have considered having a baby at an earlier age? Why?
  - While religious institutions punish unwed mothers, is there anyway that religion discriminates against infertile women?
  - Have you found any comfort in religion?

### Your Partner:

- How does your partner feel about your condition?
  - Do you ever talk about how he feels?
  - Do you ever fear that he might leave you?
  - Do you think that because you struggling to have children, its putting strain on your relationship?
- Have you ever thought that the problem might be with your partner?

### Appendix 16 continued: Interview schedule 3

- Have you discussed this possibility with your partner?
- How old is your partner?
- Do you think that it is possible for a man to be infertile?
- Do you know of any couples where the man is infertile?
- Do people talk about male infertility?
- Which is worse, if a man is infertile or the woman is infertile?
- Do you think that infertility is a woman's problem or a couple's problem?
- Is it important to have your own children?
  - If yes, why is it important to give birth to your own children
  - If no, why?
- Is it important to your partner that you give birth to your own child?
- Do you think that having a baby will complete your relationship with your partner?

#### Stress and Infertility:

- Do you experience any stress due to your condition?
- I would like to read a few statements about stress and infertility and ask you if it applies to you and how?
  1. Are you obsessed with your condition? So much so that you think of anything else?
  2. Do you feel that God or the Devil is punishing you or that you are bewitched?
  3. Have you isolated yourself from the support networks of friends and family?
  4. Do you sleep a lot?
  5. Do you seek escape in drinking or drugs (illegal or over the counter)?
  6. Do you feel alone?
  7. Are you unable to talk about your infertility?
  8. Do you feel angry or resentful towards your partner?
  9. Do you think that your partner doesn't understand what you are going through or doesn't want a child as much as you do?
  10. Have you lost interest in sex?
  11. Do you feel like a sexual failure?
  12. Do you feel like your life is a failure?
  13. Do you feel that you have no goals or ambitions beyond having child?

## Appendix 17: Interview schedule 4

### INTERVIEW 4: PERCEPTIONS ON MOTHERHOOD:

#### Perceptions of motherhood:

- What does motherhood mean to you?
- Do you think that all women should be mothers?
  - Explain your answer
- Do you feel pressure to have a child?
- Do you think that a child fills a void in a woman's life, which cannot be filled by anything else?
  - Explain your answer?
  - Will a child fill a void in your life?
  - Have you considered that your life might be fulfilling without a child?
- Do you think that all women are naturally motherly?
  - Do you have that maternal instinct?
- What does motherhood mean to you in a situation where you not being able to have a baby?
- How would you describe a 'good mother'?
- What does being a 'good mother' mean in your community?
- Is respectability important to good mothers?
- How would you describe a 'bad mother'?
  - Do you think that 'bad mothers' exist or are they just misunderstood?
- What does being a 'bad mother' mean in your community?
- Do you think that having a child gives a woman status?
- Is it really that important to have children?
  - Do women have choice if they want children?
  - What would other women in the community say if they knew of a woman who chose not to have children? What would you say?
    - Do you think that motherhood is a positive or negative experience?
    - If you could choose would you prefer to have a son or daughter?
  - Does the sex of the baby matter?
- Would you prefer to have a small or large family? Why?
- If the treatment is successful and you fall pregnant, would you try for another baby? Why?

#### The Right Circumstances:

- Do you think that there are ideal circumstances, when to have children?
  - If yes, what do think are the ideal circumstances to have children?
  - If no, explain your answer.
  - Do women or her community dictate these circumstances?
- While a baby's birth is always seen as a happy occasion, but are there circumstance when a baby's birth is not a happy occasion in family?
- Do you think that women consider the costs of having a baby?
  - Have you considered the cost of having a baby?
  - At the moment are you able to financially support a baby?

## Appendix 17 continued: Interview schedule 4

- Why that particular age?
  - Did you ever wonder if you should have had a child at an earlier age?
- At what age did you think you would have a baby?
- What do you think of young girls who have babies?
- Do you think that Teenage pregnancy is a problem in your community?
- Do you think that teenage mothers are too young to be good mothers? What do you think they would need to be good mothers?
- Do you think that teenage mothers are throwing their lives away?
- Is teenage motherhood always a bad thing or any there positive aspect to it?
- How do you handle your infertility in a context where motherhood is seen as being very important for adult women?

### Celebrity Motherhood:

- Do you read the newspaper or any magazines or listen to the radio or watch television?
  - Have seen any stories of celebrities that are pregnant or about the birth of celebrity babies?
  - Do you think that they are newsworthy?
  - Do you think that these celebrities have made being pregnant fashionable?
  - Have you ever seen any of the following? (Show pictures of expectant celebrity mothers)
  - Why do you think that people are fascinated by these images?
  - Do you think the imagery presented in the media of celebrity mothers and children are realistic or unrealistic to the Cape Flats context?
  - Do these images appeal to you in any way?
  - Have you ever, throughout your life wished that you had the life of a celebrity?
- What do you think of the new trend amongst celebrities to adopt babies? Why do you think they are choosing to adopt instead of having their own?
- How is a 'good mother' supposed to represent herself?
- How do other women in your community expect 'good mothers' to represent themselves?
- What do you think of mothers who dress fashionable (too young or inappropriate)?
- What do you think of mothers who buy their babies, baby Nike's and baby Levi's?
  - Why do you think they do that?
  - What do think they are trying to say?
  - Do you think it's more the mothers or the fathers?
  - Would you do the same?
- What do you think of mothers that dress like this? (Show pictures)
  - How are pregnant women supposed to dress?
  - How are mothers supposed to dress?

## Appendix 17 continued: Interview schedule 4

- What would other women in your community say if a pregnant woman dressed like this?
  - What would other women in your community say if a mother dressed like this?
  - How would they let her know that they do not approve of the way that she is dressing?
  - Would they skinner (gossip) about the way that she is dressing?
- Are the expectations of 'good motherhood' in your community compatible with the image of the 'good motherhood' in the media?

### Representations of Infertility:

- Do you ever feel overwhelmed by seeing all the emphasis on motherhood around you? In your family, community, in shopping malls, on television and magazines.
- Do you watch *The Bold & the Beautiful*?
  - If yes: how did you react to Amber's inability to have children? Could you relate to what's she's going through?
  - Do you think that Brooke, who falls pregnant from any man that she sleeps with, is a realistic portrayal of how 'difficult' it is to fall pregnant?
  - Have you noticed that when a couple has sex on the show, most of the time, the women will be pregnant afterwards, which means that they are having unprotected sex. What do you think of this message that this is putting out to young girls who watch the show?
  - What do you think of the way that mothers are represented in the show? Most of the time they are just interfering in their children's lives
  - If the response was 'no' to the Bold and Beautiful question, do you watch any other television shows in which a woman is struggling to fall pregnant?
  - What is the show and who is the character?
  - Do you relate to her?
- Have you read any magazine or newspapers article about infertility?
  - If yes, what did it say? Was the information helpful?
  - If no, do you think that there should be more articles in newspapers and magazines about infertility?

### Other types of mothers:

- What do you think of women who:
  - Have children but work fulltime?
  - Chooses not have children and prioritizes her career?
  - Who cannot have children at all?
  - Struggle to have children?
- Do you think that lesbian couples should have access to infertility treatment?
- Do you think that single women should have access to infertility treatment?

## **Appendix 17 continued: Interview schedule 4**

- Do you think that unmarried women should have access to infertility treatment?
- When you were small, what did your mother tell you about how a mother is suppose to act?
- In your eyes, what is a woman's role in the home? What is a man's role in the home?
- Do you think that it is better being a working mother who can financially provide for her child or does being a stay-at home mother outweighs the financial gains of formal employment?
- What would be the ideal to you? Stay at home or being a working mother? Explain your answer?
- Would go work and allow your partner to take care of the children and domestic responsibilities?

University of Cape Town

## Appendix 17 continued: Interview schedule 4

**Figure 1.1**



**Figure 1.2**



**Figure 1.3**





Appendix 17 continued: Interview schedule 4

Figure 2.1

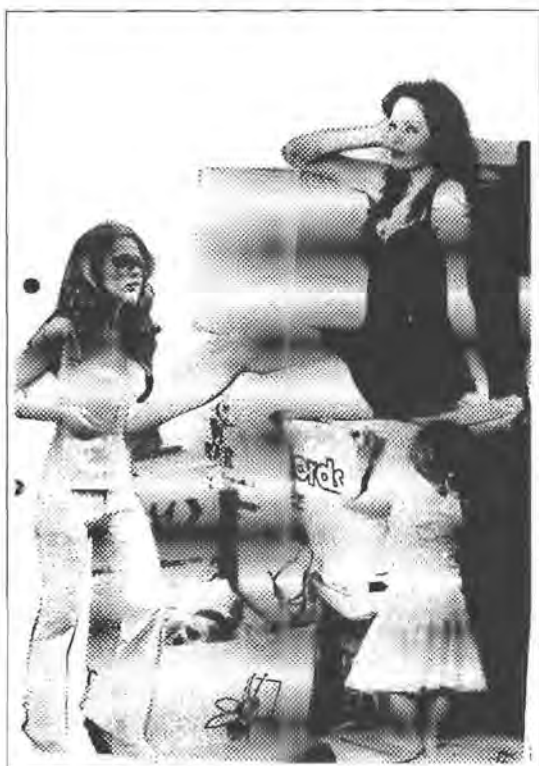


Figure 2.2



Figure 3.1

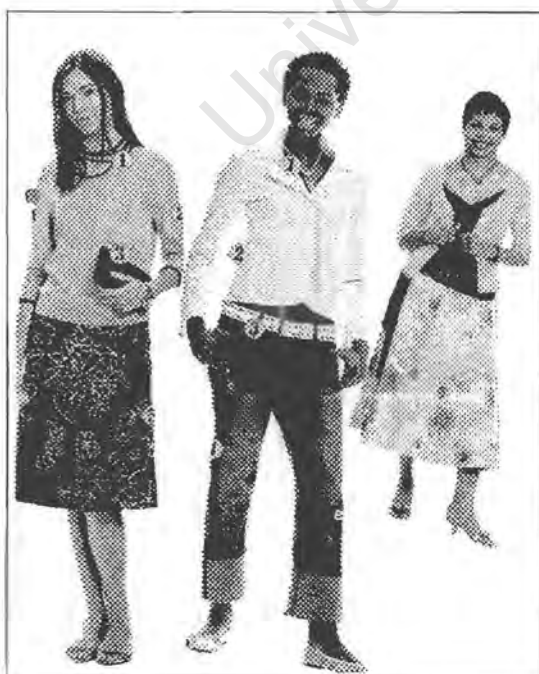


Figure 3.2



Appendix 17 continued: Interview schedule 4

Figure 4.1



Figure 4.2



Figure 5



## **Appendix 18: Interview schedule for Sister Williams**

### **INTERVIEW SCHEDULE FOR SISTER WILLIAMS:**

1. From your personal position, how do you perceive infertile women? For example, I see these women as women of strength and determination because struggling to fall pregnant is a difficult issue to deal with.
2. You have been working at the clinic for a few years now and you know how people in Manenberg think. How do people from this area perceive infertile women?
3. Why do you think that women don't want to talk about infertility?
4. What tests does the nursing staff at the clinic perform to determine if a woman has fertility problems?
5. Do married or unmarried women make up the bulk of patients seeking family planning or treatment for reproductive problems?
6. Could you please explain the process that a woman has to go through if she wants to access infertility treatment?
7. Do unmarried women have access to government assisted infertility treatment? If no, why not?
8. To your knowledge, do you think that the state provides adequate infertility treatment?
  - o Do you think that infertility treatment received at government clinics or hospitals sufficient or the best that's on the market?
  - o What could be done to improve this service?
9. What are the biggest problems that face the public health sector at the moment?

## Appendix 19: Interview schedule for focus group with mothers

### INTERVIEW SCHEDULE FOR FOCUS GROUP WITH MOTHERS- ENGLISH:

- What does it mean to be a mother?
- How would you describe a good mother?
- What does being a good mother mean in your community?
- Is respectability important to good mothers?
- How would you describe a 'bad mother'?
  - Do you think that 'bad mothers' exist or are they just misunderstood?
- What does being a 'bad mother' mean in your community?
- Has your meaning of motherhood changed over the years?
  - Has there been any change?
  - Did it become easier or more difficult?
    - Is there a difference in the way that your mother was with you and the way you are with your children?
    - Is it important in your community to be a mother?
    - Do you think that all women should be mothers?
  - Explain your answer
- Do you think that all women are naturally motherly?
- Does being a mother have an impact on how you as a woman are seen by your family/community?
- Does having children give you status amongst other women?
- Does it mean that you're a true woman?
- Is it important to have children when you're in a relationship?
  - Is having a child important to women? Or is more important for your husband or family?
- When in a woman's life is it important to have children?
  - Is it important in your teenage years?
  - Is it important in your twenties?
  - Is it important in your thirties?
  - Is it important in your forties?
  - Is it important in your fifties?
  - At what age is it the most important to have children?
- Is it important that a woman gives birth to her own children?
- Is a woman who adopts children seen in the same class, as women who give birth to their own children?
- How do you feel about women who choose not to have their own children? And choose to rather adopt children?
- How do you feel about women who choose not to have any children at all?
  - How does the community feel about this?

## **Appendix 19 continued: Interview schedule for focus group with mothers**

- What do you think is more important? To be a mother or to have a good job?
  - What does the community see as being more important?
- How do you feel about women who struggle to have children?
  - Do you feel sorry for women who are struggling to have children?
  - How does the community feel about women who struggle to have children?
- What do you think could be the cause that women struggle to have children?
- Do you think that people have more respect for mothers than women who do not have children?
- If you knew of someone who is in a relationship for more than a year and she doesn't have children, why do you think that she doesn't have children?
  - Could it be due to the possibility that she is using birth control or condoms?
  - Is it acceptable in your community to use this?
- What are your first thoughts about the reason for her childlessness when you think of an acquaintance that doesn't have children?
- What are your first thoughts about the reason for her childlessness when you think of a friend who doesn't have children?
- What should infertile women do about their situation?
  - Should they accept it?
  - Should they seek treatment or not?
- Have you ever made the effort to ask someone why she doesn't have children?
  - What did she say to you?
- Have you ever used another woman's infertility as a means to insult her?
- Do people gossip about women who do not have children? Why do they gossip about it?
- Can a infertile woman be seen as a true woman?
- Childbirth is seen as natural process, so are infertile women seen as abnormal?

## Appendix 20: World Health Organization statistics

Country	Year	Physicians		Nurses		Community health workers		Health management and support workers	
		Number	Density per 1000 population	Number	Density per 1000 population	Number	Density per 1000 population	Number	Density per 1000 population
South Africa	2004	34 829	0.77	184 459	4.08	14 306	0.32	22 859	0.51
<b>AFRICA</b>									
Mozambique	2004	514	0.03	3947	0.21	---	---	9491	0.49
Zimbabwe	2004	2 086	0.16	9 357	0.72	581	0.04	---	---
Zambia	2004	1 264	0.12	16 990	1.56	---	---	10 853	0.99
<b>DEVELOPING COUNTRIES</b>									
Bangladesh	2004	34 485	0.26	20 334	0.14	46 202	0.31	---	---
India	2004	654 825	0.60	865 135	0.80	50 393	0.05	---	---
Pakistan	2004	116 298	0.74	48 446	0.31	65 999	0.42	203 337	1.29
<b>DEVELOPED COUNTRIES</b>									
Canada	2003	65 583	2.14	309 576	9.95	---	---	---	---
Germany	2004	277 885	3.37	801 677	9.72	---	---	---	---
France	2004	203 487	3.37	437 525	7.24	---	---	---	---

## **Appendix 21: Transcript of interview with Veon**

**(This is the first interview conducted for the first session. The remaining transcripts are considered too lengthy to include in this document.)**

**Bianca: “So can you please tell me your story?”**

Veon: “Where do I begin?”

**Bianca: “Wherever you want to.”**

Veon: “Okay, I was nineteen when I got married the first time. We gave ourselves about space for six months before we were going to start a family. At the end of the six months, I could see changes in his behavior and things like that because normally people think that naturally in the first two months, something should be there.

Uhmhhh, after the six months, I consulted, Uhmhhh, Groote Schuur’s Infertility Clinic. Then they told me I should be married for a year.”

**B: “Uhmhhh.”**

V: “Okay, then I waited that year but during that year.... I mean a lot of people told me ‘Nah, you not a woman’”

**B: “Uh”**

V: “ ‘What’s wrong with you because so many people have babies like’ and ... like in the first two months or three months and look you almost married a year already.’

And Uhmhhh, then the abuse from my father-in-law started. He use to tease me, he.... Use to tell me ‘Yes, maybe my son should go with someone else just to have a baby.’ Things like that and I mean, the way it made me feel was totally like...”

**B: “It broke your spirit down.”**

V: “Exactly, I just left everything. Okay, and then after the year, I went back. Okay, they gave me a Pap smear and gave me another appointment.”

**B: “You went back to the infertility clinic?”**

V: “Yes, and they gave me another appointment three months after that one. AFTER A YEAR, then they sent me the results of the Pap smear saying that I should go for another Pap smear because they detected something. I went privately and the Pap smear came back negative, nothing was wrong and then I didn’t worry because then I thought okay, since everything is fine.”

**B: “Uh”**

V: “And that was the last six months of the marriage. Uhmhhh, I can recall when we went to this, Sandvlei...”

**B: “Uhmhhh”**

V: “We had a little picnic there and then as I was lying in the sun, they started the teasing again.”

**B: “Who was this?”**

V: “My father-in-law, my husband (we both laughed), ex-husband and his sister. And I just pretended to ignore them.”

**B: “What did they say to you?”**

V: “Like Uhmhhh, things like ‘*Daa’ lé die choekoe*’ (she laughed) things like that and ‘maybe you not doing her right’ and things like that. You know, it sounds bad as it is.”

**B: “That’s private stuff.”**

V: “JA, but I mean it sounds petty or whatever but...”

**B: “It doesn’t sound petty to me.”**

V: “Okay, okay then I just ignored it. And I recall I was lying on my tummy and I just felt this stabbing pain but then it was my father-in-law jumping on my back. So I didn’t know he was going to do that, so naturally I didn’t tense up or anything. And



then he said ‘Ag, man it won’t cause any damage, cause you damaged goods already.’”

**B: “I would have smacked that man.”**

V: “Okay, I left it. I spoke to my husband about it and he just dismissed it. Okay, THEN I didn’t know he had someone on the side, that’s another thing. And then one evening, he just stayed out. It was a Friday and he came back the MONDAY. Okay, fine I wasn’t one to say anything about it or to complain or whatever and then he came with.....I told him ‘No, man I don’t think this is going to work out, I’ll rather just move back to my mother’s place’ because we just, our yards actually was just opposite each other. And I said ‘I’m going to move back to my mommy’s place.’ And then the crocodile tears came. And the crying and the begging and the kneeling on the floor and the keeping of the leg and the pulling of the leg (we both laughed) and all of those. Then I thought, okay, I mean it’s my husband. I thought okay, fine and then we did the DEED. But I’m telling you, I didn’t know that he came from somebody else. He didn’t even have the decency to go and wash or whatever, I mean. And afterwards, I only found out. So we did the deed and I’m telling you, the evening I had such PAIN, I can’t describe it, I had, I had... I couldn’t move, I couldn’t get up, couldn’t even CRY properly because of the pain and I’ve never experienced anything like that before.”

**B: “So let me get this right. He came from his stukkje on the side to you and he slept with you?”**

V: “Yes, but I mean I thought okay, it was a boy’s weekend or whatever.”

**B: “Ja”**

V: “And, okay fine. And then I suspected no, man something is wrong because this never happened before.”

**B: “Uhmhhh”**

V: “In the year that I’ve known him or married to him. And funny enough I only found out about this, a year ago, A YEAR AGO... A year ago, I only found this out but in any case I told him that’s something wasn’t right inside and HE WAS SO SUPPORTIVE for the first week, you won’t imagine. And I suspected it but I didn’t have proof or anything. And then beating came. He use to beat me and say those same words like ‘you cant even give me a child’, ‘you damaged goods’, and ‘I don’t know why I got married to you’ because you... you know, it was just about the baby, it was the baby, the baby thing, the baby thing. And then after a while I said to myself ‘No, I’m not going to take this anymore because I’m worth much more than that.’ And it took me a while to leave him but I moved in with my friend’s parents. They actually HID me and after two weeks, as I came from work, it was my first job, not my first job but I mean the first job after I left him, he was sitting there. And the crocodile tears came again but by that time, Uhmhhh, I just lost all love and affection for him.”

**B: “Uh”**

V: “And what I reminded myself of was the words that they said to me, the way he beat me. They way they, the whole family treated me and I just said ‘No, I’m not going back’ and I never did. Uhmhhh, then I had another relationship, strictly platonic with a much older guy.”

**B: “Uhmhhh”**

V: “And I mean he taught me self-worth and taught me how to be independent and all that. That lasted about a year and then he said its time for me to spread my wings and do things that I wanted to do because I mean I was only twenty-one at that time. And it was quite hard for me because I tended to RELY on him for support, for everything

except the money because I worked for my own money. Although he gave me everything.”

**B: “Uh”**

V: “But so he said he cant be there FOREVER, because he also feels that he wants to meet someone else not because he didn’t love me in that way or anything but he just feels, he just felt he couldn’t give me what I wanted, and that was a family, a husband someday. And I always said I would never get married again but Uhmhhh, so we parted, we still friends and then I just took a step back and I said to myself ‘I don’t need a man in my life to make me happy’ and if I’m gonna have children then it would come naturally. And then over the years I’ve had ONE other relationship that lasted four years. And nothing else happened.”

**B: “Where you trying to fall pregnant while you were in that relationship?”**

V: “With the four years?”

**B: “Yes”**

V: “Yes, in the second year. So I thought okay....I WASN’T ON BIRTH CONTROL OR ANYTHING.”

**B: “Okay”**

V: “But we used condoms, so now and then. So I mean that also Uhmhhh shook me a bit because I just felt hey, now and then condoms, periods regular, NOTHING. And its like if I’m one day late, I would run to the store, pregnancy test.... NEGATIVE and then I sit again (she laughed)”

**B: “So you were disappointed?”**

V: “Definitely, but I mean I just dismissed it and just brush it off “Aah, its not meant to be yet’ but Oh, and another thing, while I was married I missed a period (she laughed) and its actually so funny now. I missed a period and my mother was working

for Mowbray Maternity, all the years and Uhmhhh, then she, then she... she just came in and she said 'Uhmhhh, you look so different....'

**B: "You're glowing."**

V: "Ja (she laughed) But okay I was on a diet that time also, so I thought Wow, maybe it could be and I took a pregnancy test. I actually bought me three, just to make sure (we both laughed) and I waited till the next morning cause I wanted the fresh urine, I wanted to use the freshest that I could and okay, fine. The first one didn't have any results, the second one POSITIVE, Ooh, I was overjoyed and the smiles, no one could stop me. (We both laughed) and then I took a third one..."

**B: "Uhmhhh."**

V: "NEGATIVE."

**B: "So how did you feel?"**

V: "I was totally; I was like up there and then straight down again. I was on cloud nine and I missed cloud one and I just fell to the earth. And I told my mother 'No, something's wrong, the one says positive, the one has no results and the one says negative.' Okay, so she said one of the sisters at work said I must send my sample and they'll do it for me at work. And I couldn't sleep that evening and she came back 'NO, NOTHING'. Okay, then I thought to myself 'Oh, well' and that's where all the abuse and everything else started."

**B: "Uhmhhh"**

V: "Okay, with the guy with four years, he was very supportive always, till this day..."

**B: "You're still friends?"**

V: "JA, we're still friends and he always told me 'if we should get married, it wouldn't be to have children, it would be, to be with me' because of the type of

person I am, because of the way I make him feel and the way that we just connected and all that. But in the mean time he didn't know the toll it was taking on me."

**B: "Uhhmmm"**

V: "Feeling that something is wrong and not knowing what to do, okay and he took me to doctors, Dr. Abrahams, JA, I can still remember, in Woodstock. Okay, she did a Pap smear, NEGATIVE. I thought 'Okay, good shot. Everything is fine.' She gave me an injection of some sort; I can't remember what it was called or what it was."

**B: "Do you know what it was for?"**

V: "NO."

**B: "So she didn't explain why she gave you that?"**

V: "No, not really. She just said it would clear up I don't know what but in any case I was so overjoyed because the Pap Smear came back negative so maybe its not something severe or whatever. Okay fine, I was all happy and smiles and the discharge that I told you about, she gave me something, I don't know if it was antibiotics or something."

**B: "Can you just repeat what you said about the discharge?"**

V: "Oh (she laughed) the milky discharge, she gave me, I remember she gave me antibiotics. She gave me twenty. I took two per day and it was cleared up, fine everything was hunky-dory but still nothing and this was well in our second year now that we were trying to have a baby. And now the mother's old saying 'The Lord is not going to give you a child if you not married.' So I said 'BUT, YES I WAS MARRIED. Cant God just see me in' or you know, thing like that. But can't he just give me child."

**B: "Well on the Flats that's not true."**

(She laughed)

V: "But I mean, then I stressed and I told her 'why does, God says he's not unfair, okay I understand but to me it seems unfair because there is twelve year olds, thirteen year olds, they just have to walk past the guy and then there's something in there, a bun in the oven. Here I'M TRYING MY ASS OFF to push it as hard as I can but nothing is happening'. And I mean it's been years"

**B: "And you financially stable and what not."**

V: "You understand"

**B: "And you were in a stable relationship."**

V: "And everything but nothing happened. But 'No, the Lord is not going to give you a baby if you not married.' So I said 'Well, I'm not going to pressure myself to get married, just to have a baby. And at the end of the day I sit with the same problem (she laughed) Okay fine, and everything went fine in our relationship but then, you know FRIENDS."

**B: "Whose friends?"**

V: "My friends and his friends. There the stuff started again... because some of my friends I haven't seen like for two, three years and I tend to avoid people if I know that they are pregnant, I tend to avoid them especially if they my friends."

**B: "Why?"**

V: "Cause I know what the question is going to be."

**B: "What?"**

V: "When are you going to have a baby? (We both laughed) Don't you have a baby yet? Why aren't you pregnant yet? I mean things like that and I'm older than them. And then the friends started '*Haai, het julle nog ie 'n baby ie'?*' '*Hoe lank gan hulle nou al uit al?*' And it just started and I just couldn't take it because now and I mean, I wasn't getting any younger either."

**B: "You only twenty-seven relax."**

V: "People say ONLY twenty-seven but I mean to me its like thirty, the clock is run out (She laughed) by the age of thirty because I mean I don't want to sit with a baby, when I'm thirty-five. My mommy was forty-two when she had me and I mean she's sixty-nine now and I am twenty-seven. I don't, REALLY, I don't want to be a great-grandma and still have a baby that's young (I laughed) although I love her to death and everything and I'm grateful for her having me but still..."

**B: "My mother was in her late thirties when she had my sister."**

V: "But she wasn't forty-two was she?"

**B: "No, but my one aunt was thirty-nine when she had her child but now its like a joke in the family when its my cousin's twenty-first, it will be my aunt's sixtieth in the same year."**

V: "So you understand what I mean. My mom is turning seventy, next year and I mean seventy, twenty-eight. It's like a BIG DIFFERENCE."

**B: "So you feel like her granddaughter."**

V: "You understand and I'm her last and the baby."

**B: "Uhmhhh."**

V: "Okay and our relationship went well and everything and then I just started, I don't know what happened, but I just started partying. It's like just relieving my stress somewhere else. I started parting, going to clubs, LEAVING HIM AT HOME but I mean I started looking for excuses to start an argument and just saying 'Look here just stay because you ruining me evening, I'm leaving now' but in the mean time he didn't start anything. And then Uhmhhh, our relationship started..."

**B: Falling apart?”**

V: “Yes, just spiraling. It’s totally my responsibility that I take upon me why we broke up and everything. But I think it was a long time coming because in the first place I wasn’t that IN LOVE with him. I cared about him and everything but not the ‘in love’ part.”

**B: “Uh”**

V: “So it was bound just to fall apart sometime because I wasn’t intending on marrying him anyway. And the often told me not to waste his time and my time because I mean we were going out for well about four years. And then we just broke up and then I met my husband.”

**B: “What’s your husband’s name by the way?”**

V: “Carl.”

**B: “Carl”**

V: “And we got to know each other.”

**B: “Very quickly.”**

V: “Yes (she laughed) we met in June, end of June. We started visiting in July and by August we were a couple. September he asked me to marry him and then we started buying our little things and then we got married in February, this year the twenty-second. Didn’t have anything big because I thought rather put the money aside or buy things that I’m going to need than people just eat and then still *skinnering* about it.

*‘Daa’ was ie’ die gewies ie’, her dji van daai gekry?’ (We both laughed)”*

**B: “You have the same mentality as me. I said that people just go the weddings for food.”**

V: “It’s true.”

**B: “And then they still skinner about it afterwards.”**



V: "ALWAYS. And also 'Het *djy haa* 'rok gesien? Ne, Kan sy nie iets bieter e' an getrek it ie' or you know things like that. So I thought 'No, rather use that money' and even till this day he will... there were many nights when I use to cry and tell him 'I know we only married for a month but this is not a feeling that I've been having for a month. It's been years already and I just feel, I just feel like a REJECT because whey between all my sisters, my mother and the WHOLE of my family, they all have kids but I don't. What is so special about them? What do I lack that they have? Because I love kids because I mean I can give a child a life. At least a plate of food because there are so many kinds who don't even have piece of breads in the evening or in the morning. And most importantly I can give them the love and support that they need.' And of, the whole of our road, all that girls are pregnant."

**B: "How old are they?"**

V: "ALL OF THEM. The one is eighteen, the twins are twenty and the one actually lost the baby last year because Uhmhhh, her boyfriends, I think he beat her or something because they were having a fist fight in the road. But we didn't know that both of them were pregnant at the same time. Then an argument came and then the brother got in and then it came out, IN THE MIDDLE OF THE ROAD, all the dirty laundry. (I laughed) about beating her and she losing the baby. So that happened the previous week already, so we only found out a week later cause the Voice was a bit late. (I laughed) The Voice was definitely late. But I mean she's pregnant now again."

**B: "She's fertile."**

V: "Now that's what I'm saying. It's like they just, they just glare or glimpse at the guy and there's something there. It depresses me and it breaks my heart to think that here I'm married and I can... and none of them work, my husband works. It's not much but I mean we can give the love and support and everything and there they just

having babies like its going out of fashion or something. And most of them are friends that, and have friends that are not appropriate, really and the lifestyle in the home its terrible cause you cant put someone to bed and least of all a baby. But then you swear and I mean that's the way of their lives in the house. Its continuous swearing and arguments and always a fight and whatever. And there are many times when I cry and tell him 'I don't know why I'm here? Why was I born?' because so many times my mommy tell me 'Yes, but the Lord made a woman....'

**B: "To have children."**

V: "Yes, to have children'. And many times, it does say in the Bible that you must go for prayer, and SO I DID. Another story, I go for prayer and the pastor ask me 'where you at the doctor already?' (She laughed) I was so surprised; I was just looking at him. So I said 'Uhmhhh, but what does that have to do with prayer because the thing is this, if you pray for something and you believe, then why you asking me about the doctor?' But why don't you go the doctor, maybe it's just your tubes that are blocked or something like that, medically. It's not a sin to go to a doctor because the Lord gives them knowledge. Okay, so I had so much faith in prayer and the prayer just, also just out the door. And it seems like everything I try to do, it just depresses me further because then somebody else will have something else to say. And like the pastor for example, 'why don't you just go to the doctor?' So I told him 'the fact that I'm on medical aid, medical aid is very expensive. I don't have three-hundred rand (R300) to go the doctor at like one.... one week or, I cant even take a one-fifty just to go for a Pap smear because the medical aid is deducting such a lot of money but I cant use it.' So if that was extra money in the account, it would be fine."

**B: "Uhmhhh."**

V: "But the reason why he put me on the medical aid as soon as possible, so I could go but now I can't use it. So I don't know, I really don't know what to do anymore and one thing that I'll say that pisses me off is the government supplies so many free contraceptives, birth control."

**B: "Uh"**

V: "Everything but the kids doesn't use it. I heard once, me and my mommy were at the clinic in Hanover Park and there were a couple of girls. I swear they were between thirteen and probable sixteen or fifteen and they were actually challenging each other to get pregnant just to get that one-eighty or one-seventy a month. Is it? Or is it one-twenty a month?"

**B: "I think its one-eighty."**

V: "I mean what you can do with that."

**B: "We actual spoke about that once. You'll think 'what the hell am I going to do with that little money? Cause what can you do with that? NOTHING. Like nappies are so expensive...."**

V: "Exactly."

**B: "Or about when the baby gets sick. You think of all those things."**

V: "Cause I tell my mommy 'if I go to a club, I have nothing less than about four to five hundred rand in my pocket.' That is for the entire, that's just for the evening. What can you do? How can you raise a baby on a one-sixty, one-seventy or eighty, even if it was five hundred rand, it wouldn't raise a child. And they are just having them just to get those little pennies and who must sit with the baby at the end of the day?"

**B: "The grandmother?"**

V: "The granny."

**B: "Someone once said to me that the reason why a lot of single women in that area in falling pregnant is for the grant. She said it may sound stupid to us but think about it, if no one is working in the household and four women is livening in that household and they all get the grant. The one can pay the rent, the one can pay the electricity, the one can pay this and the one can pay that. But she also said that some of them will rather buy a pair of Cats of Levi's..."**

V: "Uhmhhh"

**B: "Then you get people like you who can support a child."**

V: "Exactly, I just told me husband now the other day, 'Uhmhhh, why don't the government have low-cost fertility clinics?' Okay, the fertility clinic at Groote Schuur, okay fine but to get an appointment like every three months its, and I've lived that. EVERY THREE MONTHS, every three months from now you get an appointment. If something should come up and you can't make it and you cancel it, you have to wait another three months. What results can you get from that? It just depresses you further and at the end of the day, what do you? You waited like two years to get a full examination; a full medical for every three months appointment and another two years of your life is gone. I mean if I had to wait another two years, I'll be twenty-nine, then I'll DEFINETLY be in my thirties if I have my first baby. And then if I could I would have one. My husband even said to me 'if we should find out that I couldn't have any or whatever, what about adoption?' That's another story. They want to know what your income is. They want to know if you got your own home. And I mean where is that they should give the child to a loving family. The child can eat, the child can get love and support, get schooling. It doesn't matter if you live in a small house or if you have a minimum wage, at least you can give that child what that child can't get in the system."

**B: "Uhmhhh"**

V: "There is such a lot of things going on in the system but still they would rather have the child end up in orphanages and things like that rather than to give the child to couples who would look after the child as if it was their own."

**B: "So I have a question for you. You know the stories if where the couple seemed respectable and then a few years later they find out that the child was sexually abused or whatever. You have heard stories like that?"**

V: "Ja

**B: "So what do you think of that?"**

V: "Well, there is where the love and support should come in because if you should adopt a baby, it shouldn't be taken lightly because that is your own, you should take it as if that was your own child. So whatever happens or in that child's life, you have to taken on that's your responsibility. That is why it's not a choice that should be taken lightly but I mean some people don't want to be in, don't want that complications when it comes to things like that. But those are the type of things that happen every day and I think if I could have a baby, adopt a baby or whatever, that would be the center of my life cause that is something that I have wanted for so long. It doesn't mean just because I didn't give birth to it that I can't be...."

**B: "You shouldn't love them any less."**

V: "JA, or as good a mother as someone who gave birth. There are so many people that throw their babies in bins and things like that. I mean, okay, that baby may not remember cause its still too small."

**B: "Or what if the baby dies."**

V: "Exactly, but I mean just being there, supporting that child and trying to make and give that child a better life, I think that would be ample enough. Not everybody is like



that but I mean, they can screen the couples and all of that but I mean there are so many people who would take on foster children and all of that. Then there are the down sides, kids not respecting you, if they find out or whatever. And then there are those, Uhmhhh... the social workers. They come in at any time because there was one lady; she fostered her daughter's children. Her daughter was a sex worker and actually she was a friend of mine and Uhmhhh, we would have adopted her baby, the bay she was pregnant with at the time. And I had that baby in my first marriage, I had that baby for the first six months and I mean that was the happiest six months of my life with a child. I gave him everything I could. The love, the care, I gave him everything. They brought him when he was about two months old. They agreed, Okay, we can look after the baby and after six months, if WE feel that we really want this, we could file papers and all that. And when that child got to me he had asthma, bronchitis or something, he had such lesions on his skin and I mean he looked TERRIBLE. But I mean within a month, you could see that child, and he constantly cried, but after a month he was like a happy baby because just for that love and support. My ex-husband wasn't at home much or whatever but I mean I was there. I worked and my mom just kept an eye on him, looked after him because when you adopt a child they ask who's going to look after the child when you at work. But whether you have YOUR OWN BABY, there's crèches, there are the nurseries that you put your child in. So what is the difference? You are working to give that child a better life but at the end of the day, when you get home, that child goes to his mommy and I mean that is so nice. For me, it was a pleasure to come home in the evenings even though we started having problems and all that I could still cling to the baby because that was, I felt that, that was MINE. That was the only thing that I could say was MINE and I enjoyed coming home and having him stretch his arms out, and I

could pick him up and you know, just talk to him even though he was a baby as everybody does with babies.”

**B: “JA, you talk to them like they understand what you saying.”**

V: “Yes, I would ask him little questions and just talk to him. And I worked for Edgars and the baby department was like my second home.”

**B: “They got really nice stuff.”**

V: “And I worked in Red Square with the make-up but I was constantly there. And, Uhmhhh, one of my mangers asked me ‘why are you always there?’ So I said ‘no, we are planning on adopting a baby that we are fostering for the past few months.’ And he said okay he will take me in the baby department for about a month because they need someone at the tills and I worked there for a month and I was ecstatic because I mean I could walk around on the floor and the DISCOUNT. We got thirty percent off, so you can imagine but that was also short lived because after the six months the child was happy and had everything. He had car seat, from everything he had and then we approached the grandmother, actually I DID because he was already no...no all his shit started. But I mean I was still there for this child and then the grandmother said ‘no, *Haai*, he looks so pretty and he’s well looked after’ and all that. Oh, JA and we can’t give you; we decided not having you adopt the child or whatever. Nobody knew what was happening behind closed doors but I mean then EVERYTHING of mine feel apart because I though ‘Wow if they are really going to take the...’”

**B: “The baby.”**

V: “It was like THE BABY, they were going to take MY BABY and six months. I mean you don’t even need a day to bond with a baby because they can steal your heart instantly. And then everything just went wrong and I just... and then they made me

the child's godmother. But I went about three to four times, we moved away there and three, four times I went to go look at him and so on. And I could see like everything is just not the way I would do it. He was walking around with wet nappies and a rash on his bum and this like that."

**B: "UH"**

V: "I couldn't take it, so I just didn't go back again. And that's why I feel like even though minimum wage couples, couples that, I don't mean unemployed but I mean even if they don't have a lot of money in the bank or whatever and you live from paycheck to paycheck, at least there's a plate of food, there's love, there's love, there's care, there's a roof over their head should be able to adopt children. But I would much rather WOULD WANT TO HAVE MY OWN BABY. I mean to go through that experience, the whole nine months, the PAIN and the suffering from giving birth. I mean but I feel every women gets to that stage where she wants to have a... okay I can see not you."

**B: "I bought this pregnancy magazine; it's like science-fiction movie."**

V: 'OH NO'

**B: "I don't think I would want to go through child birth."**

V: "Me and my husband we got this little game, it's not a game actually. Then we would lie in bed and watch TV and then he would say 'if we have a baby, it's going to be a rugby player.' Cause he plays rugby."

**B: "Uhhmmm"**

V: "I said 'No, if I had a choice I would accept anything but if I had a choice it would be girl.' And then he would say the bay could lay in the middle and you know, just our fantasies but I might smile and like laugh and seem like I'm enjoying it, enjoying



the conversation, not that I'm not enjoying it, just to have that fantasy but then it slips back to that 'look how long I'm trying to have a baby.'

**B: "I can hear that having a baby is very important to you, right?"**

V: "That's like the next best thing to marshmallows"

(I laughed)

V: "Really, since I can remember, like when I was little I use to have this bag, that's why I have this bag. I'm very fond of a bag. EVERYWHERE I GO, I go with a bag and I had this doll that my mommy said looked exactly like me. It wasn't a plastic it was a hard plastic. You know those old dolls, that didn't have hair but had the little twirls."

**B: "Uh"**

V: "I had one of those dolls. I took that doll everywhere and I mean since I can remember I've always had that motherly love and that motherly instinct and wanted to have a baby and walk around and show my baby off and do things and things like that. And that's why I never, Barbie Dolls? I never had one Barbie doll. All of my dolls was that baby dolls. When it came out with the boy doll that showed the private parts and everything, I had the girl and I had the boy. I had a.... they call it a *kaffirpoppie*; I had two of those, a boy and a girl. I had this doll that could shiver. If you take off the dress and the top then the baby would shiver. And I mean things like that that intrigued me. I loved to bath them and put on this and I would go to the baby shop and Uhmhhh, you know these cheap baby shops like Pep Stores or whatever?"

**B: "Uh"**

V: " And I was like sixteen already and I still had all my dolls and I would buy baby, new born baby clothes cause I knew it would fit the new born baby doll. And I mean it wasn't an obsession but it was just my way showing love and affection that I

already have and had no way to release it. I mean sixteen and a baby? I was in high school, I was in my matric year, and I just turned seventeen. And I mean that is still there. I'm so afraid I won't have the time to have my own baby and what do mean do at the end of the day? I'm not saying that he's going to do that but I mean...."

**B: "You had a bad experience of that already."**

V: "Yes, but he also longs to have a child but I can I see it."

**B: "Uh"**

V: "But he'll NEVER speak of it because he knows how I feel about it and he'll always tell me 'God will give us a child, in due time' but then I ask him 'Now how much time? Another ten years? Eight years?'"

**B: "I mean you suspected that you had endometriosis, right?"**

V: "Yes"

**B: "Now that we spoke about it earlier, I think that you feel more strongly about your suspicion and you think now that you do have, right?"**

V: "JA, because some people talk about maybe your tubes are blocked and I thought to myself 'okay, my tubes are blocked and all I need to do I have it flushed out.'"

**B: "Uh"**

V: "Sucked or whatever that they do with the tubes. And then, okay, then all my visitations with doctors and consultations always ended off, firstly with a Pap Smear and then after that, I mean its with every visit the consultation is R120, the Pap Smear on it own is one-seventy-five and then I didn't go back because where do I get the money every time and my appointments were like weekly."

**B: “Uhmhhhmm”**

V: “WHERE DO I GET THAT MONEY on a weekly basis? I mean it’s a lot of money. Now some people will say ‘now why do you want a baby, you can’t even afford the doctor’s fees.’ But the thing is this if I fell pregnant...”

**B: “On your own.”**

V: “Yes, on my own, those one-twenties and one-seventies, one-fifties if I need it...”

**B: “It adds up”**

V: “It goes to the baby.”

**B: “Ja”**

V: “Or to the house or whatever, I mean. But now they say you can’t even afford the doctor’s fees or whatever (she laughed) And what pisses me off, is the medical aid. We spend like monthly; my medical aid is R400a month, a little more than R400. He’s is also R400 but I can’t make use of it.”

**B: “Ja”**

V: “I have to wait an entire year before I can use it and then it’s limited in some areas.”

**B: “Is it just because of the full medical report that they want or is because you are newly married?”**

V: “No, not because I’m newly married. They want the Pap smear results. Because I was already at the doctor, the medical aid, this form that I had to fill in, they asked have I been to a doctor and if so, I should write it down because it could result in problems in me not, in me not being able to use the medical aid and all that. So I WAS HONEST, I TOLD THEM that I was at this doctor Parker and he said that he advised the ultra-sound and the Pap smear and look where it’s gotten me. Twelve

months I have to wait, other wise I would have waited three months. Now I have to wait the whole year.”

**B: “But don’t you, like I mean that page you were reading that I gave to earlier with all the symptoms....”**

V: “Yes”

**B: “Didn’t you say that reading that, maybe you do have it an maybe it makes you feel a bit more relieved?”**

V: “It makes me anxious and then again I don’t know. The thing is like the symptoms...”

**B: “Uh”**

V: “ You know, when I started to think okay, it could be that was when you said about its pushing against the growths (she laughed) or something because that is, the painful like intercourse that we were talking about, it feels like it goes into deep or something. I mean, it’s painful and it makes you completely turned off.”

**B: “Ja”**

V: “So that is actually because the severe period pains its not it. The only thing that I can relate to is the infertility.”

**B: “Okay”**

V: “And when you mentioned the....”

**B: “Sex thing”**

V: “The sex thing”

**B: “So you don’t know. So would you rather go to a specialist to gain clarity like I told you about the specialist that I see or what would you want to do?”**

V: “YES, if I could go the worlds, I mean the world’s best.... Uhmhhhmm...”

**B: "Best doctor?"**

V: "Yes, or the best specialist or gynae then I would do it by all means immediately but what put me off are the finances. You understand. We are people living from paycheck to paycheck and sometimes, we are SO HAPPY if there's a hundred rand left or two hundred rand left. 'Wow, we haven't been out in a long time' because I mean that also where the problems start and I don't want problems in my marriage."

**B: "Uh"**

V: "Because when you go out, you go, when you still dating you go out to this place and that place and the movies and eat out and do this and do that. Now when you married, like six months down the line, all you've seen is the four walls of the bedroom. And I mean that's all. So then its boredom."

**B: "Okay"**

V: "Then I feel I want to go to my friends, he wants to go to his friends and there's where the separation starts because you get so use to going out on your own, you don't drag your wife along or I don't drag my husband along. And that's why you so happy if there's a hundred rand left or whatever. So talking about, for some people seven hundred rand is like a drop in a bucket whereas for me I can tell you a lot I can do with seven-hundred rand."

**B: "Okay, I know I told you that I paid seven-hundred rand for my first consultation. I DIDN'T PAY IT, that's the thing, the medical aid paid it."**

V: "Now you understand what I mean, that is what gets to me."

**B: "Now the way I spoke about the doctor would you go see him?"**

V: "Definitely, from what you've told me. He's efficient, he can answer any question. You can even, like I explained to you how it feels for me inside. Its raw and all that. I mean to me it seems I can relate and I can speak openly to him and he will be able to

answer it all knowing exactly what I'm talking about. Not like he can feel it, you know (she laughed) but he'll know."

**B: "is there anything else that you want to say?"**

V: "There's such a lot things, that I can't think of (she laughed)"

**B: "Okay, then its fine, there's no pressure."**

University of Cape Town

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